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ABSTRACT

Because of concern about the communication skills of dentists from countries of the European Economic Community wishing to practice in England, a project was undertaken to develop a pilot test of English language skills focusing on listening and speaking skills in dental practice contexts. This report is a descriptive statement of the nature of dentist-patient communication in general practice and dental hospitals, the first of two parts of the project's final report. The fieldwork undertaken in early 1980 is described and a resulting preliminary description of dentist-patient interaction follows, with hypotheses concerning the perceptions dentists and their patients have of the dental consultation. The bulk of the report is an analysis of several dental consultations, with particular attention given to the problem of patients' reports of the symptoms and dentists' responses to them. The report concludes with suggestions for further research in dentist-patient communication. (Author/MSE)

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DENTIST-PATIENT COMMUNICATION

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A Report to the General Dental Council

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University of Lancaster

Lancaster, October 1980

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October 1980

1 : BACKGROUND TO THE PROJECT

(1:1). PRELIMINARIES

In the autumn of 1979 the General Dental Council approached the Department of Linguistics and Modern English Language and the Institute for English Language Education in the University of Lancaster with an invitation to discuss the problem of preparing an English Language Test for dentists from member countries of the European Economic Community who wished to practise in Britain. At the time of this initial approach, it was not certain that such an English Language Test would ever be required for actual implementation, partly because the legislative process upon which the introduction of the Test depended was not complete, and partly because only a small number of overseas dentists was likely to be involved. Nevertheless it was considered prudent to have the development of a small-scale testing scheme under way.

After discussions with the General Dental Council, the Director of the Institute for English Language Education in December 1979 proposed a three-part procedure:

(a). Preliminary fieldwork leading to a report on the nature of Dentist-Patient communication in the contexts of the general dental practice and dental hospitals;

(b). The preparation of a pilot testing scheme for overseas dentists (which would be based on the data obtained from the fieldwork of (a) and would focus on listening and speaking skills);

(c). The development of a full-scale, piloted, reliable and valid Language Testing Battery which could be administered by the General Dental Council over a number of years (and which would grow out of the experience obtained from the pilot testing scheme of (b)). The development of such a Battery would require separate provision for a full-scale research and development project.

An agreement was reached by which the Department of Linguistics and Modern English Language and the Institute for English Language Education undertook to produce two documents during the period January - September 1980.

These would be:

(a). A descriptive statement on the nature of Dentist-Patient communication in general practice and dental hospitals;

and

(b). A pilot English Language assessment scheme for overseas dentists wishing to work in general practice in Britain.

The present report addresses document (a) above. Document (b) is the subject of a separate but related annex to this report.

1 : 2 PROJECT REPORT

This report begins by describing the fieldwork which was undertaken during the period between January and August 1980. A preliminary description of dentist-patient interaction follows, with hypotheses concerning the perceptions which dentists and their patients have of the dental consultation.

The body of the report consists of a discussion of several dental consultations which attempts to apply a variety of analytical techniques to the available data. Particular attention is given to the problem of patient's reports of their symptoms and dentist's responses to these reports.

The report concludes with suggestions for further research in the area of dentist-patient communication.

2 : SUMMARY OF FIELDWORK

2 : 1 QUANTIFICATION OF FIELDWORK

Data have been collected from the following sources:

(a). An extended, unstructured interview with a dentist involved in general dental practice in the North of England;

(b). Observation, including the audio-recording of some consultations, of two dentists working in a joint general dental practice in Morecambe, Lancashire (the majority of whose patients were being treated on the National Health Service);

(c). Observation, including the audio-recording of some consultations, of a dentist working alone in a general dental practice in Morecambe, but operating two surgeries (the majority of whose patients were being treated on the N.H.S.);

(d). Observation, including audio-recording, of a dentist working alone in a general dental practice in Southport, Merseyside (the majority of whose patients were being treated privately);

(e). General observation in the periodontics and pedodontics departments of the Liverpool Dental Hospital;

(f). Observation, including the audio-recording of some consultations, of dentists working in the examinations, periodontics, pedodontics and prosthetics departments of the Liverpool Dental Hospital;

(g). Observation, including the audio-recording of some consultations, of student dentists working in the conservation, orthodontics and pedodontics departments of the Liverpool Dental Hospital.

This concentration of attention on activities at the Liverpool Dental Hospital during the first stage of research may be justified on the following grounds:

TABLE 1 : CHRONOLOGICAL DESCRIPTION OF FIELDWORK, JANUARY - AUGUST 1980

OBSERVATION NUMBER (1)	TYPE OF PRACTICE	PLACE	DENTIST (2)	DATE	TOTAL OBSERVATION TIME (3)	TOTAL RECORDING TIME (4)	NUMBER OF CONSULTATIONS (5, 6)	TOTAL DENTIST-PATIENT CONTACT TIME (5, 7)	DENTIST-PATIENT CONTACT TIME (5, 8)
1	extended, unstructured interview	University of Lancaster	(1)	20/02/80	90	-	-	-	-
2	general practice	Morecambe	(1)	27/02/80	150	-	(7	95	14)
3	general practice	Morecambe	(2)	27/02/80	165	-	(13	160	12)
4	general practice	Morecambe	(2)	14/03/80	150	96:10	13	88:10	6:47
5	general practice	Morecambe	(1)	14/03/80	150	-	(8	125	16)
6	general practice	Morecambe	(2)	21/03/80	120	-	(6	85	14)
7	general practice	Morecambe	(1)	21/03/80	120	61:50	7	58:25	8:21
8	general practice	Morecambe	(3)	27/03/80	105	-	(4	55	14)
9	general practice	Morecambe	(3)	27/03/80	105	-	(3	50	17)
10	periodontics department	Liverpool	student dentists	28/03/80	105	-	(not observed individually		)
11	periodontics department	Liverpool	student dentists	28/03/80	30	-	(not observed individually		)
12	general practice	Morecambe	(3)	29/04/80	120	87:10	5	77:25	15:29
13	examinations department	Liverpool	(4)	12/05/80	60	-	(16	40	3)
14	periodontics department	Liverpool	(5)	12/05/80	60	-	(1	45	45)
15	conservation department	Liverpool	(1)	12/05/80	120	-	(1	105	105)

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16	conservation department	Liverpool	(ii)	12/05/80	90	75:20	1	73:10	73:10
17	examinations department	Liverpool	(6)	12/05/80	90	54:45	8	43:25	5:26
18	conservation department	Liverpool	(iii)	12/05/80	60	56:35	1	55:50	55:50
19	orthodontics department	Liverpool	(7)+ (iv)	12/05/80	30	9:50	2	3:20	1:40
20	pedodontics department	Liverpool	(v)	12/05/80	45	31:30	1	30:40	30:40
21	orthodontics department	Liverpool	(8)	12/05/80	60	39:15	3	33:15	11:05
22	private practice	Southport	(9)	16/05/80	210	132:45	5	132:05	26:25
23	examinations department	Liverpool	(6)	16/06/80	75	62:25	10	50:20	5:02
24	examinations department	Liverpool	(10)	16/06/80	30	17:35	3	12:05	4:02
25	prosthetics department	Liverpool	(11)	16/06/80	105	37:00	2	35:00	17:30
26	periodontics department	Liverpool	(12)+ (vi)+ (vii)	16/06/80	135	84:05	5	79:00	15:48
27	extended, unstructured discussion	Liverpool	(5)+ (12)	23/07/80	60	-	-	-	-
NON-RECORDED TOTALS	13 observations		6 dentists; 1 student dentist		1320 minutes (22 hours)	-	(59	760 minutes (12 hours 40 mins)	13)
RECORDED TOTALS	14 observations		10 dentists; 6 student dentist		1320 minutes (22 hours)	846:15 (14 hours 6 minutes 15 seconds)	66	772:10 (12 hours 52 minutes 10 seconds)	11:42
GRAND TOTALS	27 observations		12 dentists; 7 student dentists		2640 minutes (44 hours)	-	125	1540 minutes (25 hours 40 minutes)	12

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(a). Ease of access to a large number of practising dentists and student dentists;

(b). An excellent environment for audio-recording;

(c). The availability of a considerable number of interested experts who have the time to reflect upon and discuss the purposes and characteristics of dentist-patient intercourse;

(d). Most importantly, the separation into discrete and relatively leisurely consultations of most of the activities which may be collapsed into one relatively short consultation in general practice; analysis of the communication between dentist and patient in each of periodontics, pedodontics, prosthetics, orthodontics, conservation and examinations enable an analysis to be made of the communication associated with each of these aspects of the dentist's work as they arise in general practice.

Table 1 is a chronological description of the fieldwork undertaken during the first eight months of the project (January - August 1980).

Table 2 is a quantitative summary of the fieldwork performed during this period.

The data of this Table are arranged by the following categories:

(a). General N.H.S. practice (i.e. in which the majority of patients are treated on the N.H.S.);

(b). General private practice (i.e. in which the majority of patients are treated privately);

(c). All general practice (both N.H.S. and private);

(d). Student dentists in hospital departments (i.e. conservation, orthodontics and pedodontics);

(e). Dentists in a hospital examinations department;

(f). Dentists in other hospital departments (i.e. periodontics, pedodontics and prosthetics);

TABLE 2: QUANTITATIVE SUMMARY OF FIELDWORK, JANUARY - AUGUST 1980

CATEGORY	DETAILS	OBSERVATION	RECORDINGS
(a)	General N.H.S. Practice (Observations 2 - 9 and 12)		
	Observations made	9	3
	Duration of observations (9)	1185	245:10
	Individual dentists observed	3	3
	Individual patients observed	66	25
	Duration of dentist-patient contact (10)	800	224:00
	Average duration of dentist-patient contact (10)	12	8:58
(b)	General private practice (Observation 22)		
	Observations made	1	1
	Duration of observations (9)	210	132:45
	Individual dentists observed	1	1
	Individual patients observed	5	5
	Duration of dentist-patient contact (10)	130	132:05
	Average duration of dentist-patient contact (10)	26	26:25
(c)	All General Practice (N.H.S. + Private)		
	Observations made	10	4
	Duration of observations (9)	1395	377:55
	Individual dentists observed	4	4
	Individual patients observed	71	30
	Duration of dentist-patient contact (10)	930	356:05
	Average duration of dentist-patient contact (10)	13	11:52
(d)	Student Dentists In Hospital Departments (Observations 15, 16, 18 and 20) (11)		
	Observations made	4	3
	Duration of observations (9)	315	163:25
	Individual dentists observed	4	3
	Individual patients observed	4	3
	Duration of dentist-patient contact (10)	265	159:40
	Average duration of dentist-patient contact (10)	66	53:13

TABLE 2: QUANTITATIVE SUMMARY OF FIELDWORK, JANUARY - AUGUST 1980

CATEGORY	DETAILS	OBSERVATION	RECORDINGS
(e)	Dentists In Hospital Examinations Departments (Observations 13, 17, 23 and 24)		
	Observations made	4	3
	Duration of observations(9)	255	134:45
	Individual dentists observed	3	2
	Individual patients observed	37	21
	Duration of dentist-patient contact (10)	145	105:50
	Average duration of dentist-patient contact (10)	4	5:02
(f)	Dentists in Hospital Treatment Departments (Observations 14, 19, 21, 25 and 26)		
	Observations made	5	4
	Duration of observations (9)	390	170:10
	Individual dentists observed	8	7
	Individual patients observed	13	12
	Duration of dentist-patient contact (10)	200	150:35
	Average duration of dentist-patient contact (10)	15	12:33
(g)	All Hospital Departments (Students + Dentists)		
	Observations made	13	10
	Duration of observations (9)	960	468:20
	Individual dentists observed	15	12
	Individual patients observed	54	36
	Duration of dentist-patient contact (10)	610	416:05
	Average duration of dentist-patient contact (10)	11	11:33
(h)	All Observations (12) (General practice + Hospital)		
	Observations made	23	14
	Duration of observations (9)	2355	846:15
	Individual dentists observed	19	16
	Individual patients observes	125	66
	Duration of dentist-patient contact (10)	1540	772:10
	Average duration of dantist-patient contact (10)	12	11:42

(cf footnotes 9,10,11, 12)

TABLE 3: Register of Dentists (13)

DENTIST NUMBER	WORKING ENVIRONMENT AND OTHER DETAILS	SEX	OBSERVATIONS
1	Partner in group practice (N.H.S.)	M	1, 2, 5, 7
2	Partner in group practice (N.H.S.)	M	3, 4, 6
3	Works alone, operating more than one consulting room (N.H.S.)	M	8, 9, 12
4	Dentist in hospital examinations	M	13
5	Senior hospital dentist	M	14, 27
6	Dentist in hospital examinations; native speaker of English with non-British accent	F	17, 23
7	Dentist in hospital orthodontics	M	19
8	Dentist in hospital orthodontics	M	21
9	Works alone in private practice	M	22
10	Recently qualified dentist in hospital examinations department	M	24
11	Dentist in hospital prosthetics	M	25
12	Dentist in hospital periodontics	M	26, 27
i	Student dentist in hospital conservation department	F	15
ii	Student dentist in hospital conservation department	F	16
iii	Student dentist in hospital conservation department	F	18
iv	Student dentist in hospital orthodontics dept. Non-native speaker of English	M	19
v	Student dental hygienist in hospital pedodontics department	F	20
vi	Student dentist in hospital periodontics department	F	26
vii	Student dentist in hospital periodontics department	M	26

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TABLE 4 : REGISTER OF PATIENTS (14)

CONSULTATION NUMBER (15)	PATIENT	SEX AGE	DURATION OF RECORDING (16)	DENTIST-PATIENT CONTACT TIME (16)
4:1	Mr B	M c late 40's	9:20	6:35
4:2	Mr C	M c late 40's	7:05	7:05
4:3	Mrs Jeanette H	F mid 20's	10:40	9:20
4:4	?	F 60+	7:15	7:00
4:5	Mr J	M 50+	3:00	2:20
4:6	Father T	M 40+	8:10	7:10
4:7	Mrs Betty W	F 41	4:55	4:50
4:8	Mrs K	F c 40	4:15	4:00
4:9	Mrs I	F c early 50's	4:45	4:45
4:10	Mr I	M c late 40's	3:40	3:15
4:11	Catherine	F teens	19:20	18:20
4:12	Mrs R	F c early 40's	8:50	8:35
4:13	Mrs Q	F 40+	4:55	4:55
7:1	Mrs P	F adult	8:10	8:10
7:2	Mr B	M young adult	15:45	14:15
7:3	?	M young adult	6:15	5:55
7:4	Dawn	F teens	10:30	10:15
7:5	?	M adult	6:25	5:25
7:6	?	F adult	4:05	3:50
7:7	?	F child	10:40	10:35
12:1	Sue	F 20+	23:30	18:05
12:2	Gary	M 20+	13:25	11:35
12:3	James	M c 55	20:15	19:15
12:4	Simone	F 20+	15:35	14:30
12:5	Chris	F 30+	14:25	14:00
16:1	?	M adult	75:20	73:10
17:1	?	F adult	7:15	7:00
17:2	Mr C	M young adult	2:45	2:45
17:3	?	F adult	2:35	0:35
17:4	Mrs J	F elderly	11:30	9:30
17:5	?	F adult	8:00	8:00
17:6	?	M adult	11:10	6:05
17:7	Mr A	M young adult	5:35	4:25
17:8	Mr MacM	M young adult	5:55	5:05

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CONSULTATION NUMBER (15)	PATIENT	SEX	AGE	DURATION OF RECORDING (16)	DENTIST-PATIENT CONTACT TIME (16)
18:1	Bernadette	F	teens	56:30	55:50
19:1	?	F	adult	3:00	2:15
19:2	Colin R	M	child	6:50	1:05
20:1	?	F	teens	31:30	30:40
21:1	Ruth M	F	9	9:20	6:20
21:2	Robert H	M	child	8:30	5:30
21:3	?	F	adult	21:25	21:25
22:1	Mrs E	F	adult	23:00	23:00
22:2	Mrs B	F	adult	25:25	25:25
22:3	?	F	adult	28:25	28:15
22:4	?	M	adult	23:15	22:50
22:5	?	F	teens	32:40	32:35
23:1	?	M	c 10	3:15	0:40
23:2	Maureen C	F	young adult	5:25	4:15
23:3	?	F	c 16	4:55	3:50
23:4	Jacqueline L	F	c 13	5:00	3:35
23:5	Mr T	M	c 50	7:10	6:40
23:6	Elaine R	F	18	5:50	3:30
23:7	(see 23:2 above)	F	young adult	1:00	1:00
23:8	Thomas O	M	adult	10:30	8:25
23:9	John D	M	60+	13:00	12:45
23:10	Janet D	F	20+	6:20	5:40
24:1	?	F	9	3:40	1:05
24:2	William C	M	20+	6:25	5:30
24:3	?	F	late 20's	7:30	5:30
25:1	Mrs Louise R	F	71	20:35	20:25
25:2	Mrs Joyce R	F	adult	16:25	14:35
26:1	Mr T	M	adult	16:40	15:25
26:2	?	F	teens	29:20	28:50
26:3	?	F	adult	7:40	5:45
26:4	Mrs G	F	adult	11:15	9:50
26:5	?	M	60+	19:10	19:10

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(g). All hospital departments (both dentists and student dentists);

(h). All observations (in both general practice and hospital departments).

The figures for observations 1, 10, 11 and 27 in Table 1 are not included in this summary.

It will be seen that, upto the end of August, observation of dentists actually at work (total observation time minus durations of observations 1, 10, 11 and 27) totalled 41½ hours, of which 22 hours were audio-recorded. Nineteen dentists were observed, and sixteen of these were recorded, whilst the number of patients observed reached 125, of whom 66 were recorded. The duration of dentist-patient contact during the 125 consultations totalled 25½ hours, and the duration of dentist-patient contact during the 66 recorded consultations was almost 13 hours. The dentists involved in those observations which were recorded spent approximately two-thirds of their working time in consultations: the remaining third was occupied largely by the interludes between observations and by attention to administrative matters. This explains the fact that whilst 91% of the duration of recorded consultations is occupied by dentist-patient contact, only 58% of dentists' working time is spent in contact with patients.

The average duration of each consultation is 12 minutes. However, this may vary from an average of four to five minutes per consultation in the hospital examinations department, up to an average of 53 minutes or more per consultation with student dentists. In private practice the average consultation is 26 minutes, whilst in those practices treating mostly N.H.S. patients the average is less than half of this, at between 9 and 12 minutes.

This range, from approximately 4 minutes to one hour per consultation, is to be expected. The very short consultation in the hospital examinations department serves only to identify the patients' complaint, record his medical history, and determine very broadly what treatment is needed. The patient is not treated in the examinations department, but is directed to other departments of the hospital which are able to provide the detailed attention which he requires. It is not surprising, therefore, that each consultation in the examinations department is brief. On the other hand, consultations in the other hospital departments tend to be considerably more time-consuming. In these consultations, student dentists or members of staff treat patients without being put under any pressure whatsoever to deal with a certain number of patients in a particular period. Student dentists are also obliged to interrupt their work occasionally so that it can be checked by a member of staff: this inevitably prolongs the duration of the consultation.

2 : 2 PRACTICE TYPES OBSERVED

(a). N.H.S. Group practice

The N.H.S. group practice at which observation was undertaken had three partners. Each was assisted by his own dental surgery assistant (D.S.A.). Receptionists and a dental technician supplemented the practice's staff.

(b). N.H.S. Individual practice

The only N.H.S. dentist working alone who was observed during the project operated three surgeries with the assistance of one receptionist, one D.S.A. and one dental technician. One surgery was reserved for impression and denture or brace-fitting work. The dentist also made domiciliary visits and was the company dentist for a major department store.

(c). Private practice

The private practice at which observations were made was in fact a group practice consisting of one senior partner and one junior partner. The senior partner treated the majority of his patients privately, whilst the junior partner treated most of his patients under the N.H.S. scheme. Receptionists and D.S.A.s supported the partners.

(d). Dental teaching hospital

The dental departments of the teaching hospital which were visited included orthodontics, periodontics, pedodontics, conservation, prosthetics, oral surgery and examinations. The patients were outpatients and were treated by specialist consultants and/or student dentists. Even though much of the treatment is carried out by student dentists, it is closely supervised. Patients are either referred from general dental practitioners because the patient has a special problem or patients bring themselves. The latter kind of patients, because they seek hospital treatment in preference to general dental practice treatment tend to have different needs and values from general dental practice patients. Of these patients who were observed and recorded, several had a general speech problem and several had psychiatric problems. The patient referred from a general dental practice might, for example, have a serious gum condition, or might need a special plate fitted to enable him to drink and eat normally after an oral cancer operation. Almost unlimited time is spent on patients but they may have to wait a long time to be seen. The emphasis in most departments is on educating the patient to prevent further dental problems. A dental hygienist training course is run at this hospital, and many patients receive dental hygiene treatment. The dental departments are integrated in the faculty of dentistry and practical training is a major component of undergraduate courses.

2 : 3 The conspicuousness of the reseacher

Whether the researchers were introduced to the patient or not largely depended on the individual dentist's inclination and communicative pattern. In one practice, the researchers arranged the recording equipment and then retired to the assistant's desk with pen and notebook. The patients appeared to ignore the researchers almost entirely, although the latter were occasionally included in the leave-taking stage. Both dentists in this practice managed the attaching of a microphone to the patient themselves and they did so without giving the patient any explanation:

D: Can I just pop that on there a moment it's alright it won't bite you

The researchers were not given white coats to wear for any observation or audio-recording sessions. Generally, only one researcher was present to observe and record.

In another group practice the researchers were frequently left alone with the patient after he had been ushered into the surgery. In these cases the researchers used the opportunity to introduce themselves, explaining the nature of their work and seeking the patient's permission to record his interaction with the dentist. In another practice the dentist invited the researchers to introduce themselves each time a patient came in. In the various departments of the dental hospital which were visited, complete freedom was given to approach dentists and patients concerning the recording of their interaction.

On each visit to a dental practice or surgery to observe and record, informal discussions with dentists and their assistants between consultations or at coffee-time were found to be invaluable.

Before data collection commenced, the use of a videc-recorder was considered. However, it was felt that this would introduce extra complications. Dentists would have been even less relaxed with video equipment in their surgeries than with audio equipment; also, audio equipment is less obtrusive and does not attract attention amidst the plethora of dental equipment. Video recordings might have a contribution to make at a later stage.

2 : 4 DENTIST LANGUAGE SKILLS

The language skills that dentists use during dental consultations are provisionally listed below in approximate order of frequency of use, and are broadly characterised in terms of function and text-type. This list will obviously need to be refined from further and more extended fieldwork, and is certainly implies an interactive set rather than any step-by-step sequence.

(a). Speaking (with/without eye-contact) D ⟶ P

eliciting
prompting
explaining
presenting alternatives
suggesting
instructing (+DSA)
reassuring

(b). Listening (with/without eye-contact) P ⟶ D

explanations
descriptions
information
preferences
dissatisfaction
suggestions (+DSA)
requests for information

(c). Reading

Hand-written record cards/files (self, DSA, other D's) referral letters from hospital departments/GP'S

(d). Writing

Reports for own use/DSA's use - reports for other D's ignorant of particular patients

NOTES

1. (p4)   : When more than one observer was present at the same observation, this is recorded as a single observation. When two or three observers separately observed the same dentist working in more than one surgery during the same period, however, these are each recorded as individual observations. Similarly, when two associates working in the same practice were observed during the same period, or when activities in two or more hospital departments were observed at the same time, these are recorded as separate observations.

2. (p4) Individual practising dentists or hospital lecturers, etc., are indicated by Arabic numerals ((1), (2), etc.). Individual student dentists are indicated by Roman numerals ((i), (ii), etc.). Only those dentists or students who played a 'significant' role in the consultation are indicated. (A subjective judgment has been made of the significance or otherwise of roles. Dental Surgery Assistants and other dentists not directly involved in the examination or treatment of the patient being observed have not been indicated). A brief description of each dentist and student is given in Table 3.

3. (p4) Figures are given in minutes, accurate only to the nearest fifteen minutes.

4. (p4) Figures are given in minutes and seconds, accurate to the nearest five seconds.

5. (p4) Figures enclosed in parentheses are for observations which were not audio-recorded. Figures not enclosed in parentheses are for observations which were audio-recorded.

6. (p4) With only one exception, the number of consultations is equal to the number of patients observed. In observation 23, however, one patient was observed twice (before and after having an X-ray examination). The number of patients observed in this case was, therefore, 9. The total number of patients observed during observations which were audio-recorded was, therefore, 65, and the total number of patients observed during all observations was 124. A brief description of each consultation and each patient observed during the audio-recorded observations is given in Table 4.

7. (p4) For those observations which were not audio-recorded, figures given are in minutes, accurate only to the nearest five minutes. For those observations which were recorded, figures are in minutes and seconds, accurate to the nearest five seconds. The column grand total, then, is a total of the duration of each observation (both recorded and non-recorded) accurate to the nearest five minutes.

8. (p4) For those observations which were not audio-recorded, figures given are in minutes, rounded to the nearest whole minute. For those observations which were recorded, figures given are in minutes and seconds, rounded to the nearest whole second.

9. (p7) Figures in the 'observation' column are accurate to the nearest fifteen minutes. Those in the 'Recordings' column are accurate to the nearest five seconds.

10. (p7) Figures in the 'observation' column are accurate to the nearest five minutes. Those in the 'Recordings' column are accurate to the nearest five seconds.

11. (p7) That is, those observations in which students worked alone. Observations in which students worked with, took over from or were replaced by a qualified dentist are combined with observations in which hospital dentists worked alone (category (f)).

12. (p8) But excluding observations 1, 10, 11 and 27.

13. (p9) This register lists the twelve dentists and seven students who were observed during the survey (whether or not they were audio-recorded). See also note 2 above.

14. (p10) This register lists only the sixty-five individual patients who were involved in the sixty-six consultations audio-recorded during the survey.

15. (p10) 'Consultation Number' is the observation number (from Table 1) followed by the Patient Number. Thus Consultation

Number 7 : 3 indicates the third consultation recorded during observation 7.

16. (p 10) Figures are given in minutes and seconds, accurate to the nearest five seconds.

3 : CONSULTATION PATTERNS

From our data it appears that the dental consultation consists ideally of four possible stages:

(a) the history-taking interview

(b) the diagnostic examination

(c) treatment

(d) prognosis/advice-giving

It is important to regard these stages and their sequence as being to some extent an abstraction from the actual sequence of any particular consultation. It can be said that it represents an ideal sequence which dentists recognize and address while allowing for variation on any particular occasion. Candlin, Bruton and Leather (1967b) make a similar point about doctor-patient consultations in hospital Accident and Emergency Departments. It will certainly be necessary to indicate differences between treatment in general practice and treatment in Dental Hospitals, and between new and representing patients. Where treatment will extend over several appointments, for example, the preliminary history-taking interview may be allocated to the first appointment and advice-giving to the last. Thus initiating a consultation in the middle of a course of treatment may be very perfunctory. For example, in the following consultation the patient has had an inspection a couple of weeks earlier:

D : hello Dawn

P : hello
D : have a seat alright?

P : yes thanks

D : did we just inspect you

Where as in the next extract where the patient has come for an inspection after six months, the dentist inserts the following questions into the opening sequence:

D : have you had any trouble   how're your teeth are they
  alright?

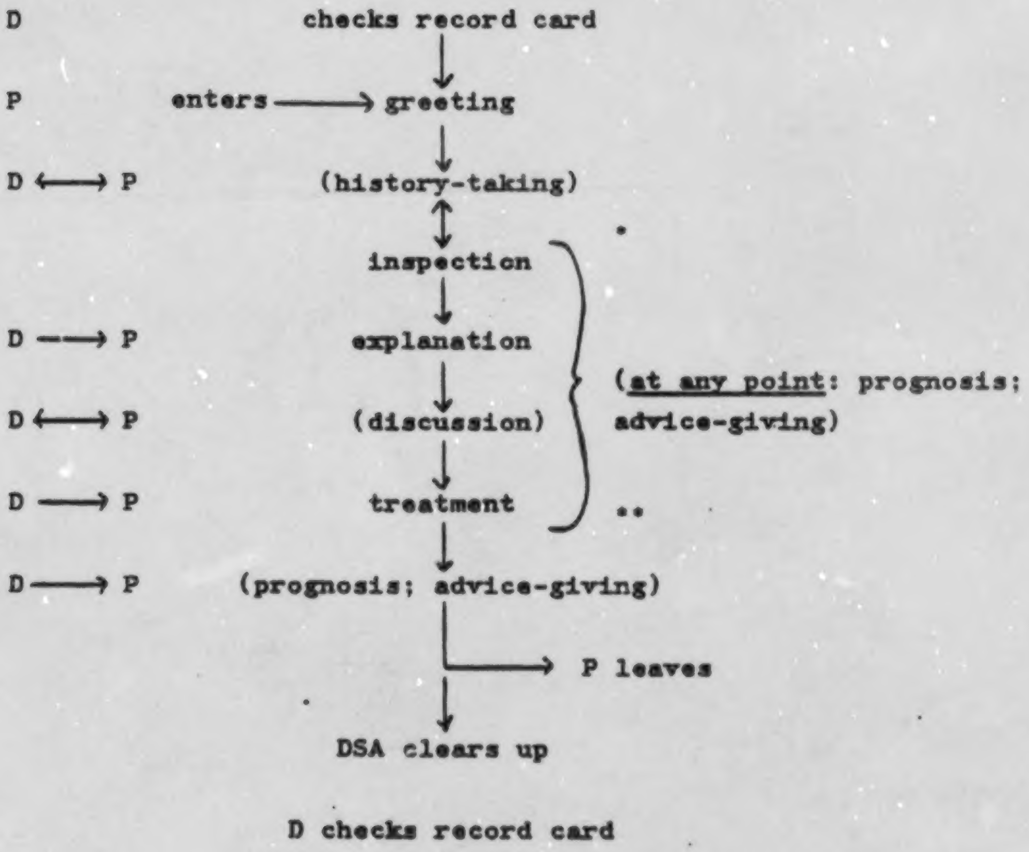
The following flow-charts give a preliminary indication of various consultation patterns in our data:

KEY

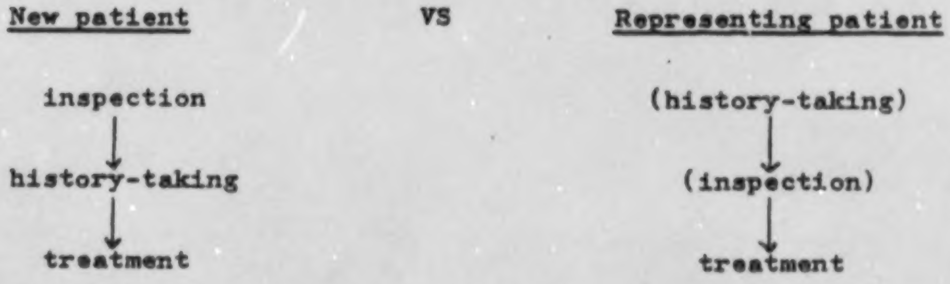
S = supervisor
SD = student dentist
D = dentist
DSA = dental surgery assistant
DH = dental hygienist
P = patient
Pt = parent
——— = direction of communication between participants
( ) = optional
/ = one of these will occur

Figure 1 (a):

General Dental Practice



* Note 1: New patients typically differ from representing patients in the following sequence:



* Note 2: Where there is a single dentist with multiple patients in different surgeries, the treatment phase may be expanded as follows, when one or more patients require local anaesthetic:

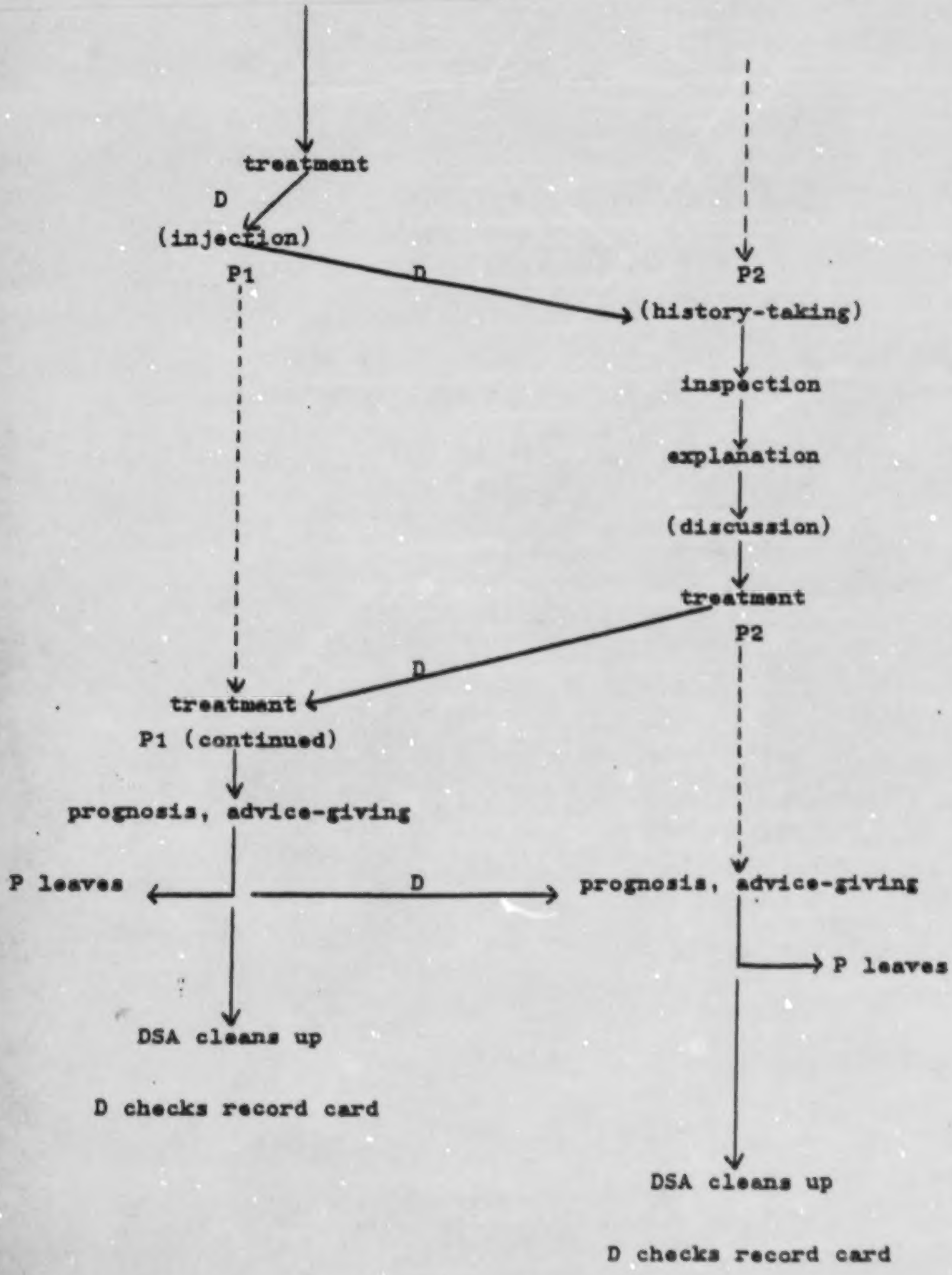


Figure 1 (b):

DSA In General Dental Practice

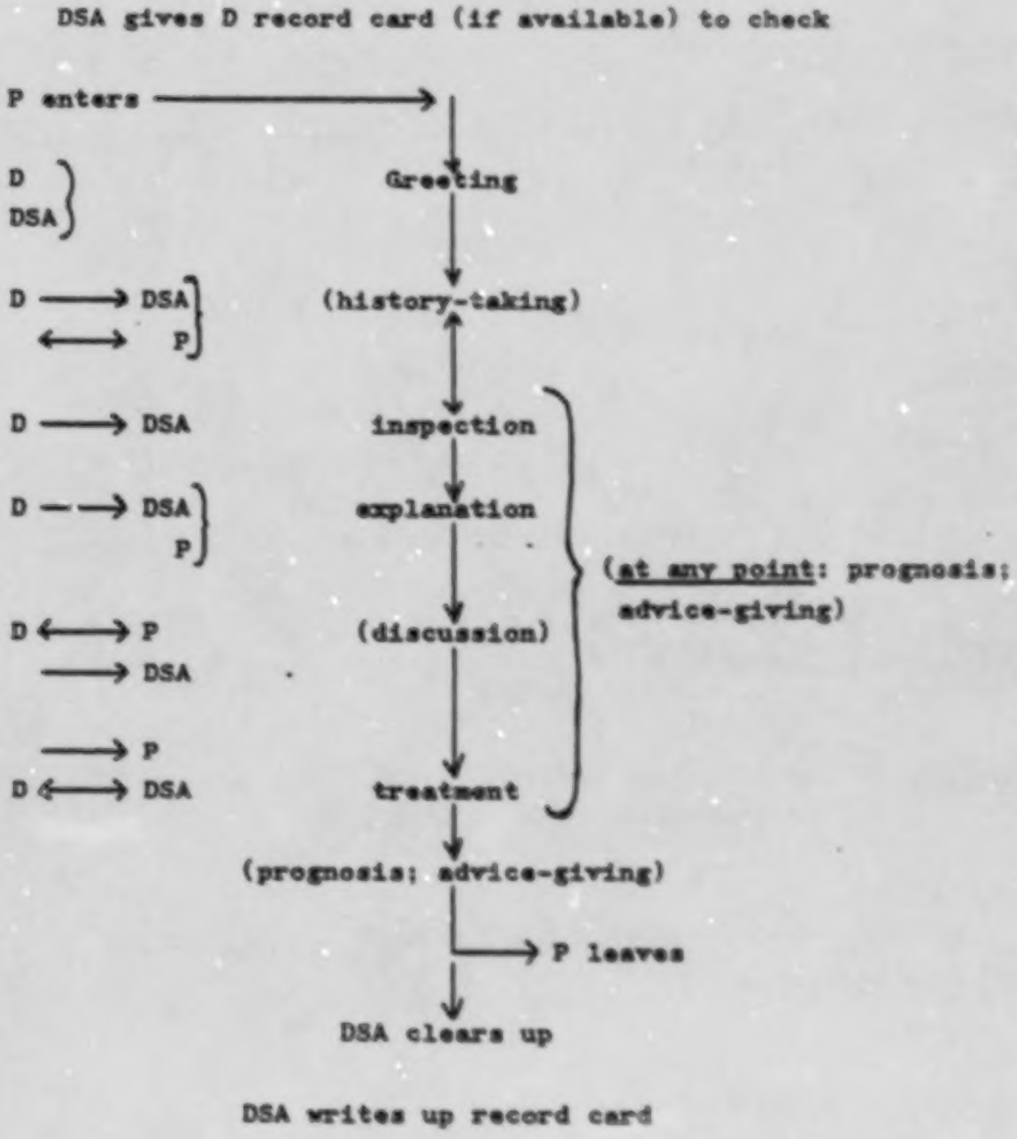


Figure 2:

Hospital Department

The hospital consultation pattern is much more complicated than that of a general dental practice. Three points, in particular, need clarification:

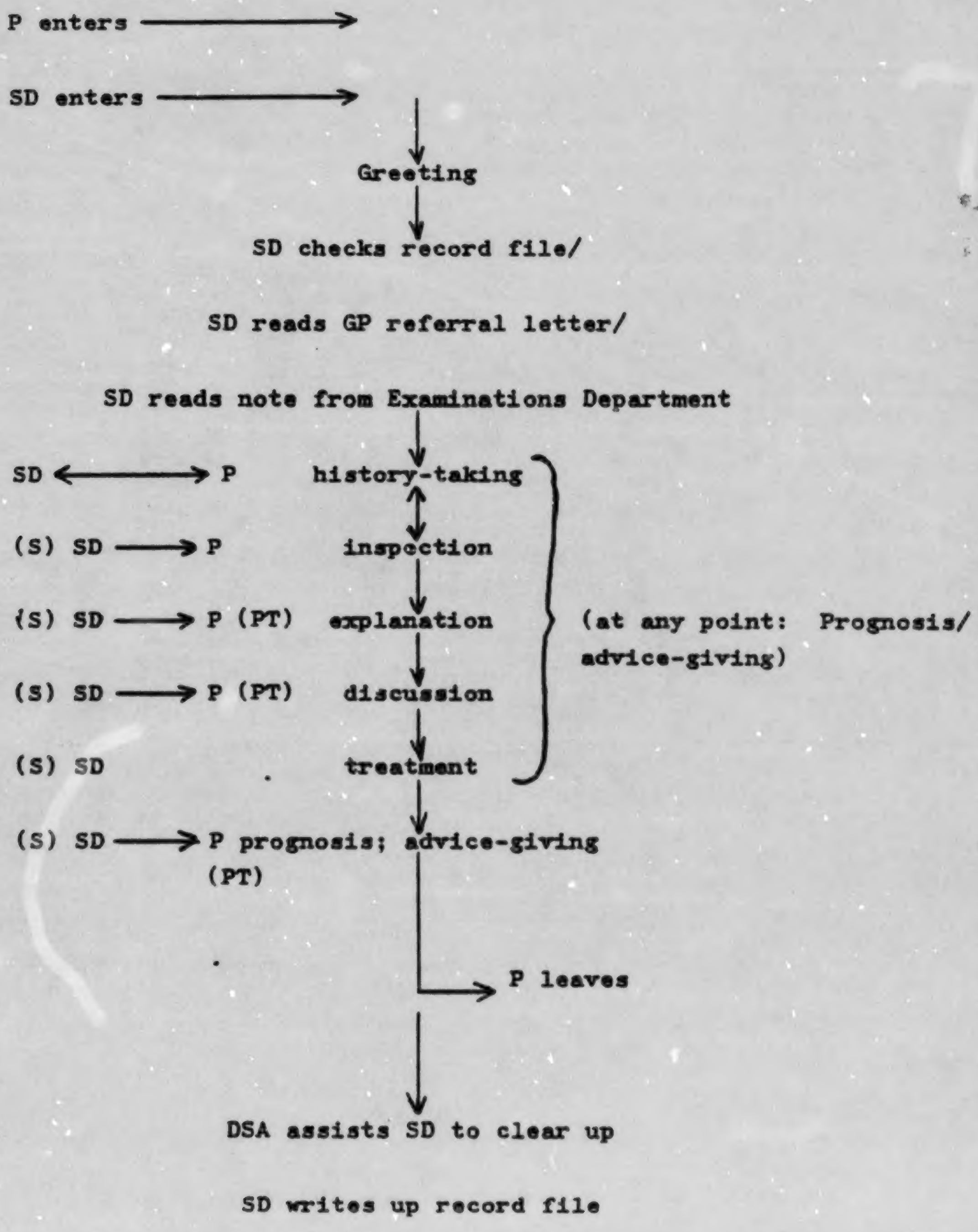
(1) Patients can be:

- (a) sent directly to a Student Dentist (SD)
- (b) be referred to a SD via a consultant/supervisor
- (c) be treated by the consultant himself (and perhaps act as a patient for a tutorial demonstration)

(2) During 1 (c) the consultant may at any time be called away to supervise, advise another SD.

(3) On Children's Wards, parents if not already present, may be called in.

Note that the following flow-chart does not address the consultation pattern in hospital Examinations Departments, but only that of Treatment Departments:


P enters
SD enters
Greeting
SD checks record file/
SD reads GP referral letter/
SD reads note from Examinations Department
SD ⟷ P history-taking
(S) SD → P inspection
(S) SD → P (PT) explanation
(S) SD → P (PT) discussion
(S) SD treatment
(at any point: Prognosis/ advice-giving)
(S) SD → P prognosis; advice-giving (PT)
P leaves
DSA assists SD to clear up
SD writes up record file

4 : PERCEPTIONS OF THE DENTAL CONSULTATION

4 : 1 PATIENT PERCEPTION OF DENTIST-PATIENT CONSULTATIONS

In the very earliest stages of the investigation it became apparent that lay opinion of dentist-patient communication was markedly negative and, apparently, almost uniform in being negative. In casual conversation with a sample of patients and former patients (a sample which, admittedly, was not necessarily representative of a wider population), the most frequently heard and most forcefully expressed opinion was that the patient does not speak at all, or that his contribution to conversation is limited to occasional grunts and groans. Other commonly held opinions were (a) that the dentist tends not to explain what treatment is being administered to the patient; and (b) that the dentist frequently invites his patient to participate in conversation or to answer questions when the latter is physically incapable of doing so because instruments have been placed in his mouth.

4:1:1: PATIENTS' CONTRIBUTIONS TO TALK

Our observations revealed that most, if not all, patients are in fact given some opportunity to speak at some point in their consultations. This opportunity may be exploited by the patient simply as an occasion for general chat not related to his treatment, as in (1):

(1) D : did you do anything exciting over the bank holiday
P : no

{D : you [just had a nice rest
{P : [just just just rest well ( )

D : pardon

P : ( )

D : hhm   I enjoyed my day off

P : (mm)

D : yes

P : (   )

D : I went away for the weekend   went home to mum

• P : where's your mum

D : pardon

• P : where   where is your

D : that's in Wigan

P : in Wigan

D : yes over to   well it's a bit further than your way isn't it

P : (yes)

D : little bit further out than St. Helen's   right there we are

(Observation 10 ; Student dentist (female) in hospital conservation department and patient (adult male))

But frequently the patient may be given an opportunity to discuss his treatment. The following exchange is typical.

(2) D : what was it you were saying about these teeth last week your
top [denture
• P : [I felt they were too full you know I my natural ones had
a slight gap very slight between the centre   I just feel that
they're just too bunched up and in a way I

P : like that
D : yeah that's right too crowded that's what you said

(observation 7 ; Dentist (male) in general practice and patient 1 (adult female))

There are also numerous occasions on which the patient does not wait for an opportunity to discuss his treatment but takes the initiative in introducing a new topic relevant to his treatment, or continues to demand further information:

(3) D : you'll have it done

P : yeah ((laugh))

D : but I have to warn you of course in all fairness that it may not succeed you know they could flare up as soon as you open them up they could flare up

• [P : [what would happen then
[D : [they still could

• P : would I have to have 'em out

D : well it could even come to that but it's only a question of time because you're going to have 'em out if you don't have anything done anyway

P : yes right

(Observation 21; Dentist (male) in private practice and patient 5 (teenage female))

There was an anomaly, then, in that observation suggested that patients are frequently involved in discussion of their treatment or in more general conversation; yet, on the other hand, the most common complaint which patients have about communication with their dentists is that they are given no opportunity to talk during consultations.

4:1:2: DENTISTS'S EXPLANATIONS OF TREATMENT ADMINISTERED

The second most common complaint among patients was that their dentists rarely explained what treatment was being administered. Again, this seemed not to be borne out by the data acquired during the investigation. Item (4) is a typical example:

(4)● D : yeah there's just a little nip at the front now (that's all)
don't jump it is a bit nippy this one

P : (aaahh)

●[D : it'll make your nose numb it'll make your [eyes water
[P : [mm ((sniff))

●[D : [(good girl) that's the worst done and there's only one
[P : [mm

D : for the bottom (now)

P : (oh yes) oh

● D : one more and then we can get everything finished for you today
it's best that way it saves you coming back again

P : yeah

● D : just for one they're not very big fillings it's just they're
in all different places so I've got to give you three injections here we go don't panic 'salright just stay wide open
wide as you can

((19 seconds))

● D : alright that's all the injections finished

P : right

D : mm

P : ((laugh))

D : we'll do a polishing for you while that's going numb this is
    just to keep your mouth dry that's all   you've had   it's
    the same as you had last time

(Observation 7 ; Dentist (male) in general practice and patient 7 (male child))

4:1:3: PHYSICAL CONSTRAINTS ON PATIENTS' RESPONSES

There were complaints that the dentist frequently expects a verbal response from his patient when the latter is constrained by the presence of instruments in his mouth, or because the dentist is actually working in the patient's mouth.

Certainly, this situation does arise occasionally, as for example in item (5):

(5) D : okay I just want you to tell what this feels like ((taps
    tooth)) alright

P : mm

D : and now I want you to tell me if any of these feel any different ((taps teeth))

P : no

D : no d'you want me does that hurt

P : mm

D : yes

P : a hi

D : that's it right it's not the big one

P : ([ )
D : [hang on is this it

• P : /əŋ /

D : is this sore

• P : /əŋə /

D : is that sore as well

• P : /ŋ /

D : and this one

P : yeah that one there

(Observation 17 ; Dentist (female) in hospital examinations department and patient 6 (adult male))

Nevertheless, the available data do not provide numerous cases of this sort. More frequently, the dentist works in silence, or provides a commentary on what he is doing which does not require any response from the patient, or pauses from his work before initiating any act to which the patient may need to respond.

Item (6) illustrates the tendency of some dentists to remain silent when working:

(6) D : pop it in and then you [can [hold it anywhere you
P : [where do I hold it

D : like [( ) yes
P : I [see

P : mm (but) I must put it [in
D : [you must have it in it won't work

P : [mm I see [mm
D : [otherwise ( ) down there somewhere that you can [move it

P :   mm
D : around a little bit   if you feel so inclined   okay let's do a
    bit more then

• ((1 minute 20 seconds))

D : would you like to er get rid of some of the water again

P : hh
D : (   ) for you

• ((8 seconds))

D : hhm okay well   so off again   okay   got that
P :   ((cough))   sorry   ((laugh)) right

D : round that way again   there we are do some from this side

• ((1 minute 5 seconds))

D : (   ) (   ) just a shade
P : mm

D : that's it

• ((1 minute 40 seconds))

D : right that does the lowers you can have a little bit of a wash
    round again if you'd like to and then we'll think about doing
    something on the uppers for you

(Observation 21 ; Dentist (male) in private practice and patient
1 (adult female))

This episode of the consultation lasts approximately five minutes. Only twenty per cent of this period, however, is occupied with talk: The rest is silence.

An example of a dentist's self-commentary which requires no response from the patient is given in item (7):

(7) D : your pain's a bit erratic isn' it some parts of the teeth seem to hurt and some don't is it the gum that's getting hurt with the sucker

P : I don't know

[D : it could [be [no you don't think so let's wash it
[P : [no I don't [think so

• D : for you anyway cos I think we've finished that one ( ) just have a little scratch at the corners 'n that's gone through the sides hasn' it I suspect ( ) ( ) decay in there what a horrible tooth let's just do a little bit more with it not a great deal and it's not the end that's sensitive I don't think that needs touching

((5 seconds))

• D : right that's that bit now I want to do a little bit more with the high speed thing too and that finishes the first tooth

((20 seconds))

D : okay now that one's nice and solid and clean and free of decay and should be alright for filling at some future time and I'm not worried too much about the filling of that at the moment and now we'll need a long bit I'll just leave a piece of wool in there just to keep it covered up and I think we'll try and get the decay out of the next one forward ( ) five wrong bit sorry about that splash shall we have it out ( )

((5 seconds))

D : ( )

((20 seconds))

• D : okay that's the next one let's try (a the third one of the series

(Observation 21 ; Dentist (male) in private practice and patient 5 (teenage female))

It will, incidentally, be interesting to investigate the perceptions which patients have of the very extensive commentary which some dentists give while they are working. It seems likely that this commentary is undirected, or only ritualistically directed towards the patient. If this is the case, do patients feel that, nevertheless, they are still being talked to, or that they are being talked at, or that they being talked about (perhaps to the Dental Surgery Assistant?) The way in which patients perceive the function of this commentary will determine how they perceive their own roles in relation to the dentist. Are they participants in a dialogue, or are they required to be no more than the impassive auditors of a monologue?

Finally, the technique of pausing briefly from work, so as to allow the patient sufficient time to respond to the dentist can be seen in item (8):

(8) D : just pop this back in to keep your (cheek) out of the way
(that's all)

((2 minutes 45 seconds))

•{D : are you alright bit shaky that one isn't {it
{P : {Yes

((50 seconds))

• D : is that still hurting you a bit

P : ( )

• D : is that hurting you

P : bit sensitive that one

{D : bit sensitive is it just occasionally or is it quite { a bit
{P : { ( )

D : because I'll give you I'll give you another little injection if you want would you like me to do that or are you happy to carry on

P : alright

D : it's alright

((4 minutes 5 seconds))

D : are you sure you don't want me to give you another injection you seem to be jumping quite a bit

P : (mm)

(Observation 16; Student dentist (female) in hospital conservation department and patient (adult male))

4 : 2 DENTIST PERCEPTION OF DENTIST-PATIENT CONSULTATIONS

The dental consultation is seen as continual surgery by most dentists and as a time for treatment and action by patients. Thus the dentist and the patient can to a degree, predict the nature of the encounter in which they are participants. The dentist is physically prepared for the consultation by having patient records to consult and equipment near at hand. If the patient is a new one, then the dentist has a standard sequence which he addresses even though there are variations in the sequences we observed. The dentist is the host to the patient, who is a visitor in his work setting, and as such, it is expected that the dentist will initiate proceedings (although there are occasions in the data where this is not so). The consultation is task-oriented with clear division between the doer and the receiver of the action. Social relationships may develop between regular patients and the dentist, but a significant proportion of patients seem to be casual patients, who attend surgery for occasional treatment.

Frequently the monologue that the dentist produces while he works is not intended to require patient response but is meant to reassure the patient, who may not be able to understand the dentist's explanation of what he is doing, but in some sense may 'feel better' for having been told. During a denture-fitting appointment in the middle of a course of treatments, the dentist in the example which follows seems to be talking to himself as he is checking the fit of the denture in the patient's mouth. The patient had been quite satisfied with the fit, until the dentist pointed out an inadequacy:

{ D : I don't think [actually you've got enough support behind
{ P : [You don't

D : your lip with this arrangement   I think we'll have to make
    the gum a bit thicker

P : mm

Legally, the patient is entitled to ask for an explanation of the treatment he is receiving and signs a consent form detailing the treatment he is to receive (Rowe, 1972). In reality, the dentist has to gauge a patient's possible reaction to any information he may receive on the treatment he is undergoing. Not surprisingly, therefore, dental talk contains frequent circumlocution and mitigation such as this dentist uses when he is about to start the last drilling stage with the slower drill:

● D : just tidying it up now, that's all

And, this dentist on giving a series of injections:

● D : it's a bit nippy it'll tend to make your eyes water

P : yeah ((Laugh))

● D : better give you one on this side too I'm afraid good and a
    little at the back

By breaking down the injection-giving into a series of small stages, the dentist enables the patient to face what can often be an extensive course of painful injections.

The patient, on the other hand, finds it difficult to describe his pain adequately for the dentist, and inconsequence, it is usually up to the concerned dentist to probe. Frequently he follows a standard sequence of exploring the position, duration and frequency of the pain but in doing so sometimes the patient is not allowed sufficient time to comprehend the implications lying behind particular questions. This dentist is in the middle of a standardised history-taking interview. To the patient it is a new experience:

• D : okay you're not a diabetic or an epileptic

P : sorry?

• {D : you're not a diabetic or an epilep {tic
{P : {no no

To be effective, the dentist needs to reassure the patient in order to gain his co-operation; the affective components of professional competence are very important (Levine et al, 1970).

An awareness that the patient-with-a-disease must be treated rather than the disease in isolation has grown in recent years. The dentist has to encourage the patient to talk to him and listen to what he says so as to be able to piece together an explanation of why the patient only comes spasmodically for treatment - usually when he is in pain. Dentists may be influenced in their impressions of patients by such indexical factors as the patient's appearance or cleanliness, but it is only by paying close attention to how a patient describes his dental condition and which aspect he concentrates on, that the dentist will be able to see how to treat his patient as a person, rather than as a mouth of teeth that need treating. On the basis of his perception of a patient, the dentist decides what information to give a patient, and this influences, consciously or unconsciously, which channel and mode of communication he uses, and even, which code he uses. Thus when the dentist is considering whether a patient will co-operate on a regime of preventative treatment, he will gauge those aspects of his message to which the patient is likely to respond.

Dentists have to be sensitive to the affective information that patients transmit. It does not take long to talk to patients, certainly not more than a few minutes of consultation time: As Selvini (1973) advocates: "first the personal relationship, then the diagnosis". The dentist is consciously or unconsciously affected by the feelings which the patient arouses in him. The fact that the nature of the dental consultation is predictable from both the dentist's and the patient's point of view (for it usually concerns surgery of a specialised nature), that NHS dentists operate under severe time constraints (seeing regular patients perhaps for fifteen minutes every six months), reduces dentist and patient awareness of the individual nature of each consultation. The personal nature of the task, conducted in a formal setting, the speed at which it is carried out, the routineness of it and its apparent predictability, all militate against the dental encounter being affectively a satisfactory experience.

It was evident from the discussions we had held with patients and dentists that they both have different awarenesses of the nature of the dental consultation and the communication appropriate to it. Most dentists with whom we spoke, hold the view that, ideally, they should be engaged in preventative rather than restorative dentistry, none the less a substantial proportion of their patients seem not to have understood this purpose. For many patients, the dental consultation resembles an endurance test during which, at best, the cause of their pain is removed, but they do not necessarily emerge from the surgery feeling 'better', only relieved. Many dentists are aware of this but are:

> inclined to erect defences against the tensions experienced in the surgery and to scorn the suggestion that apprehension and discomfort still form the major barrier to both treatment and the acceptance of good dental health practices.
>
> (Lazar, 1967)

A staff member of the dental hospital we visited suggested that because patients are so apprehensive about encountering the dentist, they are unable to relax and take in the information the dentist gives them. Dentists inturn, are aware of the tension in their patients and this often creates stress in them also, to the extent of the case of one dentist who was unable to work for four years owing to the stressful nature of the work (Marks & Wilks, 1979).

Occasionally, the information the dentist imparts is understood too well. One patient, attending the periolontic department of the dental hospital we visited, was complaining of sensitive gums. Towards the end of the dentist-patient history-taking interview, the dentist asked her how often and for how long she cleaned her teeth. Her reply was:

P : four times a day for at least five minutes

The dentist's reaction was that this was too frequent and that was the cause of her gum condition. The patient had over-reacted to the message: you must clean your teeth regularly and often. After the patient had gone, the dentist remarked that patients are told to clean their teeth twice daily for five minutes each time because they are not expected to be thorough. If patients cleaned their teeth thoroughly for five minutes, once every two days would be enough. In this patient's case, the dentist had not perceived what kind of person she was and therefore how she would react to his message. Another dentist in our discussion remarked on the number of patients who were dissatisfied with the fit of their dentures despite the fact that the dentures were well-made and appeared suitable. It seems that the patients had never been convinced by the dentist who made them that they were a good fit and would need only perseverance to make them comfortable.

We are suggesting that dentists and patients have differing perceptions and expectations concerning the dental encounter and that only rarely are all participants satisfied with the outcome.

Much of the dissatisfaction seems to stem from differing perceptions as to the purpose of the communication between the participants and different attitudes to the consultation setting, as well as the different status and role each participant assumes the other on occasion to be maintaining.

4:2:1: STATUS AND ROLE OF THE DENTIST AND PATIENT

If the line of argument that:

> In entering (a) position, the incumbent finds that he must take on the whole array of action encompassed by the corresponding role
>
> (Goffman, 1961:87)

is followed, it appears that, participants in a recognisable organised setting have expectations concerning others and their own behavioural patterns, and that the incumbent of a role may have openly-known functions to perform in a predictable sequence of regularly-performed activities. The dentist would appear to occupy such a role.

The only information that the dentist has of the patient at the first visit is that the patient has sought his expertise and is, therefore, prepared to a certain degree, to accept his advice and to comply with his suggestions. The certain degree to which the patient is prepared to do this is negotiable and will depend largely on the dentist's successful communicative skills. If the communication is successful, the interaction between dentist and patient may lead to:

> a mutual orientation of the participants (i.e. the dentist and patient) and a meshing-together of their activity.
>
> (ibid: 95)

Within the dental surgery setting, role differentiation may consist of he who treats (the dentist); he who is treated (the patient); he who organises (the dentist, and to a certain extent, the assistant); and he who observes (the assistant, possibly, or even the patient).

If the dentist, by virtue of the expectations of his role, wishes to influence the patient to change his behaviour, he will not want the patient to be an observer or to remain passive. In so far as he can, due to the constraints of lack of expertise and confidence and the physical limitations of his being operated upon, the patient will be encouraged to participate. Thus the dentist, as participant, will have the function, not only of maintaining his own poise, but also of safeguarding the poise, and also the involvement of others. This may involve the dentist in displaying distance from his role - perhaps by coming 'down' to the level of the patient and giving an analogy of cleaning kitchen equipment to cleaning one's teeth as in the consultation reported below in Section 5:2:6: - so as to relax the patient and help her understand the information that the dentist is giving her.

The dentist may, then, be under pressure to modulate his own demands and expectations in order to achieve the involvement of the other participants. He may have to soften his commands to requests, despite his status and role privileges, because co-operation is better won than demanded. And indeed, this appears to be true in the data examined for this report: a substantial proportion of the dentist's instructions is formed as requests. Those instructions which are overt instructions are generally given to the assistant , who, in the nature of her relationship with the dentist, is already involved in the activity in a way that the patient is not.

As manager of the activity, the dentist may need to distract the patient, as for instance in the consultation reported below in section 5:2:2:,

D8 : Getting a bit duller now James isn't it but it started off brighter than it is now

D8 is a comment about the weather made just prior to the dentist commencing surgery. The dentist may need to mark the end of the critical action phase and the beginning of less critical phases, as does the dentist in the consultation reported below in section 5:2:4: in D34.

D34 : good have a wash out will you

These attempts to relax the patient are functionally useful. The dentist may also need to mark or frame the central task of the activity so that the patient knows his concentration and co-operation are particularly important at this stage, as the dentist does in the consultation reported in section 5:2:2: below in D10:

{D10 : well if you do want me to stop when I'm working James just
touch your chin I'll stop immediately if you {do that
{P : {mm mmm

{D : starting round your mouth on the {left hand side starting now
{P : {mm

Although the dentist is expected to manage the encounter, the patient expects to be seen as the central figure in it, as it is his dental problem which is the reason for the encounter. The dentist responds to this by making the patient as comfortable as possible in the setting and 'rewarding' him with evaluative comments such as in the following extract from the consultation reported in 5:2:1: below

{D : and you're still able to clean I see it was very good wasn't
it {before you got down to some six per cent and uh I think
{P : {yes

D : I was fairly amazed was I not w- we were both fairly pleased
anyway I won't say amazed

Although the substance of a task activity such as the dental encounter may seem to be restricted to situated role activity, the style, manner and guise in which the task is performed by the participants is subject to individual modulation. Participants therefore look for signs of 'leakage' about an individual's personal style.

To a certain extent, role players are involved in deception; in playing a role they are not necessarily being themselves. There may be occasions when the interaction does not go as anticipated as for the dentist in the consultation reported in 5:2:4: below:

D : you've not had rheumatic fever

P : no

D : d'you've any medical thing that you take tablets for any medical condition D14
P : no P13

P : no P14

D : no quite fit D15

P : yeah P15

D : apart from your tooth ache D16

P : yes P16

D : okay when did you last have a tooth out D17

● P : oh about five years ago I just had a filling P17

D : oh you just had a filling D18

● P : yeah I'd I think two three or four something like that P18

D : well I'll make this numb for you and we'll get rid of that one because it's beyond filling quite honestly it's er it's hopeless just stay as wide as you can small nip that's all fine just a bit cold I'll just put a little in at the side to make the gum there numb fine okay D19

SILENCE

D : how long is it since you actually had a tooth out D20

P : can't remember P19

D : you can't remember no D21

The participants will seek means to restore the equilibrium by preserving the face of the other participants and this may be done by giving lip-service to the other participants' utterances, concealing personal reactions and substituting false messages (Ekman and Friesen, 1969), as the patient may be doing in the example just mentioned.

However while the face-preserving strategies are being utilised, the participants will be analysing each other's behaviour for leakage as to their true feelings. It is possibly easier for dentists to perceive 'non-verbal leakage' in their patients than it is for patients to perceive it in their dentists, because the dentist is practised in and 'used to' his role, whereas the patient has to learn and adapt his behaviour during the encounter, and is therefore less likely to give out a consistent image in his relationship with the dentist.

This initial disadvantage of the patient in his relationship with the dentist often reinforces the social distance between them, but this may in turn help the patient retain confidence in the dentist as his adviser, and to carry out instructions concerning self-care obediently. As people have a tendency (whether consciously or not) to seek advice from people whom they respect and possibly perceive as of higher social status than themselves (Banton, 1965), this difference in status discourages familiarity between the majority of patients and their dentists and enables the dentist to be more impersonal and professional. The consultation reported in 5:2:2: below is of particular interest because the patient seeks to reduce the social distance between himself and the dentist.

A participant in his contact with others:

> tends to act out . . . a line - that is, a pattern of verbal and non-verbal acts by which he expresses his view

> of the situation and through this his evaluation of the participants, especially himself.
>
> (Goffman, 1967:5)

The individual tends to behave according to his balancing of two rules, that of maintaining his self-respect and that of showing consideration to the face of the participants he interacts with. Thus to study social interaction is to study the language of tact, diplomacy and strategy and its harmony or discord with non-verbal behaviour. The encounters discussed below reveal dental strategies, some of which are overt, and therefore informative, to the patient, and some of which are hidden in the data. The patient is not revealed as having planned strategies, or ones that 'pay off', and this in itself is an indication of the dentist's control and, therefore, dominance of the proceedings.

For the interaction in a dental encounter to have any measure of success, the negotiation of it must be as favourable as possible to all the participants. The encounter must capture the participants' attention as the dentist does in the following extract from the consultation reported in section 5:2:6: below with his analogy of cleaning kitchen equipment.

D : erm what I was going to say is living in Southport where you've got this very hard water I'll give you an example of exactly the same sort of thinking you have saucepans and they are clean D15 D

P : yes P14

D : look inside your kettle 'sall full er lime same water for both D16 E
P : yes quite P15

P : yes P16
D : the only difference is you put your hand in the saucepan and you clean it D17 F

P : yeah P17

D : but you don't put your hand in the kettle and clean it D18 G
not very often and it's exactly the same in your mouth
if you could turn your teeth inside out ever week or
two you could they'd look they would
P : they would (because) P18

D : stay the same both sides so it isn't er it isn't D19 H
P : mm I see P19

D : just the fact that it's on the inside it gets dirtier D20
it's because you aren't cleaning and you can't see it
P : it deposits P20

D : that that's the big problem D21
P : mm P21

As the patient is virtually obliged to be involved in the encounter, any unease he may feel about this must be reduced. Thus the dentist will try to put him at his ease by mitigating his own demands.

In similar vein, the dental consultation between the participants - dentist and patient - will not be successful unless a stable balance is maintained between them. As we have seen in the extract above (p 43) from the consultation reported in section 5:2:1: the dentist's praising of the patient's task attempts to clean his teeth properly, contributes to the maintenance of the patient's involvement in the proceedings.

However

> the formal status hierarchy in an organization creates obstacles to the free flow of communication.
>
> (Blau and Scott, 1963)

It makes participants selective of the information they communicate; the dentist modifies his message according to his perceptions of patient-type and the patient modifies his message to the dentist according to his perception of what he thinks the dentist will want to hear. The dentist who wants to communicate well with his patient may display distance from his role and act as if the encounter is a consultation or co-operative effort between equals. The dentist in the consultation reported in section 5:2:2: below, with his frequent use of the patient's first name, attempts this as the following examples show:

D : you like a wee injection if we're going to potter about with fillings and things James you said you like it numbed up for fillings.

Or

D : getting a bit duller now James isn't it but it started off brighter than it is now

Or

{ D : if you'd like to rinse out { now for me James
{ P : { yup thank you   will do

It is possible that the patient's attempts later in the encounter to initiate conversation, and the later stages of the encounter, result from the dentist's display of solidarity with the patient. But generally speaking, the data that have been collected and are examplified here, provide evidence for Gross and Stone's contention (1964) that the participant who is in command of the territory has the advantage over the visitor to his territory and consequently is able to maintain poise more easily.

4:2:2: STATUS AND ROLES AND INTERPERSONAL BEHAVIOUR

While talking, the speaker has to assess the listener's attitude to what he is saying, and in doing so he will look for the listener to display comprehension and interest. The patient as listener may know that he is being watched for this and may display the appropriate behaviour and conceal his anxiety or lack of comprehension. The patient may thus be anxious, exactly because he knows that his behaviour both verbal and non-verbal, is being scrutinised for professional reasons. The setting of the dental surgery which demands physical proximity may also be partly responsible for the social distance between the participants. Moreover, in any interpersonal situation, participants will frequently present a censored version of themselves for public inspection because they will suppress behaviour which they perceive to be 'out of line'. We may say that the image that the patient, for example, will present of himself following an initial encounter with his dentist will largely depend on the former's perceptions of the dentist's reactions to him. Thus participants in social interaction

> find it necessary to project an image for participants to be able to categorise one another (because) they need guidance on how to respond to each other
>
> (Argyle, 1967:125)

But in an unfamiliar setting, where the participants consider themselves strangers to one another, their interpersonal behaviour will be cautious and fall back on ritual because disclosure of information about self risks disapproval until what the other disapproves of is known. Furthermore, as far as the dentist is concerned, more loss of face is probably involved during a formal occasion, such as the dental consultation (than for the patient) where his position depends on his display of competence and expertise.

Since the dentist has an overall plan as to how the consultation should proceed, he will be able to plan his responses and initiates (initiating utterances), so that he may delay his responses to a patient utterance until a later, more appropriate, stage of the encounter, when he will be able to modify his response, if he wishes, on the basis of the patient's interim utterances. The patient does not have the experience and, therefore, the foreknowledge to be able to plan his verbal responses and is consequently at a disadvantage in any attempt to initiate activity or take control of the proceedings. Thus the dentist will combine in subtle fashion his timing of utterances, his gestures and tone.

It has been asserted that;

> Dominance is partly a matter of who speaks most, partly of the degrees of deference with which A and B treat other, of whose ideas are to be taken most seriously, and of who shall for the purposes of the encounter be regarded as the more important person.
>
> (Ibid: 53)

One of the points made is section 5:2:1: below and as we have seen in 4:1:1: above, is that the dentist generally talks more than the patient. Analysis of our data reveals that this is particularly so in the work stages, where talking concerns the patient's dental condition.

Deference is a harder factor to attribute to participants. The patient indicates respect for the dentist professionally by complying with the dentist's utterances and instructions, but it needs to be investigated how far this respect is extendable outside the dental consultation setting. The dentist has to demonstrate concern for his patient but not normally respect for the patient's dental opinions. The question as to who is the more important person is therefore open to debate. The patient is the reason for the encounter and provides the need for the dentist's professional role and as far as the patient is concerned, the dentist is important because he is seen as having a specific skill that the patient lacks and needs. Nevertheless, the patient seeks the dentist's assistance because he perceives his problem as important to himself. Both participants preserve their own self-esteem by contributing to the self-esteem of the other; the dentist's self-esteem is confirmed by the patient's respect for his professional competence and possibly, social superiority, and the patient's is confirmed by the dentist's display of concern for and approval of the patient's good behaviour.

By contributing to the other's self-esteem, the dentist and the patient contribute, indirectly, to their own by ensuring the other's concern for them. If this is successful and is developed over several encounters, the dentist and patient become mutually orientated to each other as in the consultation reported in Section 5:2:1: below, where the dentist told the observer after the consultation that he was not at all interested in emigrating to Canada, but liked the patient, particularly as the patient had responded so well to dental self-care education. Presumably the patient liked the dentist because the results of the dentist's advice had been to his benefit.

It appears possible then to suggest, from our data even at this preliminary stage, that the dentist has the dominant role through as Argyle (1967:58) asserts, having the formal power of task leader and being less dependent on a successful outcome, and being in a position to 'reward' the patient.

Following Berkowitz (1956), a diagram of dental task activity could be posited thus:

D = Dentist
P = Patient
DSA = Dental Surgery Assistant

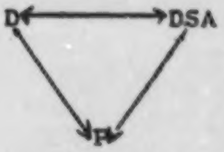


Figure 3

The patient being the central figure in the activity. But if a similar diagram is drawn to desribe the verbal activity it would look like this:

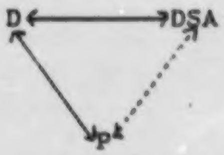


Figure 4

with the dentist as the central participant.

5. ANALYSING DENTIST-PATIENT COMMUNICATION

5.1 METHODS OF ANALYSIS

If Brown and Levinson (1978) are right, participants in discourse bring to an encounter sets of assumptions and strategies. Following Goffman (1967), they contend that people are mutually orientated to preserve each other's face and that because people are rational they will choose particular means to that end. The factors that influence participants' choice of strategies include, clarity, efficiency, politeness and responsibility or non-responsibility for any ensuing actions. In order to assess whether a linguistic act (or non-linguistic act) is a positive or negative threat to the other participant's face, the speaker will weight the sociological implications of what he wants to say against the distribution of social distance and power between himself and the addressee and the relevance of these variables in a particular, cultural setting. The advantage of subjecting language use to strategic analysis is that the exceptions or breaches of normal practice can be understood by investigating the rational sources for these occurrences. This approach circumvents the problems of, for example, the formal analysis of speaker style where the quest is the discovery of rules that can apply in only an arbitrary way to an example of well-bounded and ritualised discourse. The dental encounter might seem to be such an event. However, observation of dental discourse reveals that it is subject to change of direction and redefinition and is as 'unscripted' (Levinson, 1979:368) as other fields of discourse. The advantage, then, of Brown and Levinson's approach is that it can make explicit underlying presuppositions which are implicit in the verbal behaviour and the non-verbal behaviour that occurs. In other words, it expands and explains that which is not overt in the language by explaining the language in relation to the context of its use, and the interaction, by the participants, of verbal and non-verbal behaviour. It claims to provide a synthesis of an event, whereas a more analytical method, such, for example, that provided by Sinclair and Coulthard (1975) offers a 'dissection' of the parts while being not necessarily capable of explaining a speech event taken as a whole.

Levinson asserts:

> In assigning functions to ... utterances ... we depend both on the meaning of the words ... and on the possible roles that utterance can play within ... a game

He also comments that an important aspect of the analysis of activity-types and the language use therein, is the degree to which speech is an integral part of each activity. These comments are relevant to the analysis of dental encounters. Some stages of the typical encounter, for example, history-taking and advice-giving, are largely talking activity stages, whereas the treatment stage, and even the inspection stage on some occasions, are mainly non-verbal activity stages. Knowing the rules of the game facilitates the explication of functions of talk and its interaction with silence and non-verbal activity.

Levinson continues in the same paper to emphasise the importance of explicating the structure of an activity which he believes is:

> rationally and functionally adapted to the point or goal of the activity in question, that is the function or functions that members of the society see the activity as having.
>
> (ibid:369)

The structure of an activity (that is, its division into episodes, or sub-episodes) sets up specific expectations concerning inferences that can be made of an activity. For example, in the history-taking stage of the dental encounter we know that the intention of the history-taker is to ascertain whether the patient has a medical condition that is likely to restrict the range of available dental options that are non-hazardous for him. The patient may have an inkling of this intention but may not see the relevance of the individual questions that are put to him such as: "Have you had rheumatic fever, or hepatitis?" (see 5.2.3 below Transcript, D17 and 18).But if the analyst can make such basic assumptions about the intentions of the questioner,the activity which occurs becomes explicable. This example implies,however

> that to participate properly in (an) activity you have to know more than just how to answer questions
>
> (ibid: 384)

This puts the dentist in an advantageous position compared with that of the patient. The dentist knows, creates the 'rules' of the language game, so how, one might ask, can the patient ever learn to play the game to his own satisfaction? This point is a further indication - albeit a theoretical one - that the dentist exerts control over the consultation, particularly when, at the same time, the patient is mollified through the dentist's communicative skill at preserving the patient's face. Levinson's discussion of how knowledge of activity-types in part determines the role of language in activities, and what the participants' strategies within activities are, would seem to be particularly relevant for the analysis of our dental data.

The sequencing which occurs between actions may be far removed from the words which set the actions in motion or comment on them. Pittinger Hockett and Danehy (1960) developed nine principles concerning conversational analysis. The seventh, which concerns the continuous adjustment of firstly, the participants to one another, and secondly, the nature and purpose of the encounter, is extended in Labov and Fanshel (1977). The latter believe that actions and utterances are regularly interlinked in chains of exchanges and that our experience of the dynamic nature of conversation depends upon a matrix of utterances and actions being bound together by a web of understandings and reactions among the participants. They are interested in devising a method of analysis which displays the interwovenness of discourse layers - one that will take account of shifts from one discourse frame to another within one encounter. They admit that the cross-sectional analysis which they suggest is like a 'frozen snapshot', but they justify it by making explicit the underlying assumptions, presuppositions and implications that precede and follow each 'snapshot'.

Nonetheless, their analytical method still remains two-dimensional in that it concentrates on the 'surface' horizontal axis. The analyses of the dental encounters offered below are similarly two-dimensional, and although this approach does allow substantial explanation, as set out below, any complete analysis would have to take into account all layers of discourse. It would involve expounding the vertical axis and fitting it onto the horizontal, making what would be a 'three-dimensional' explanation of the data.

In the sub-sections that follow we experiment in a non-technical way with some of these alternatives, conscious that the consultation data we have collected will admit of much richer and more detailed analyses, given a full-scale study and the opportunity, not afforded by the nature of this Report, to apply more technical linguistic tools.

5.2. LANGUAGE IN THE CONSULTATION

We have chosen a number of different features of the dentist-patient consultation to illustrate, in this Section, from our data. The selection is significant in that the examples bear upon earlier discussion in Section 4 of the differences between the participants in the consultation seen as a social encounter. Dentists and patients vary in their perceptions of the event to which they are both party, 'power' is unequally distributed between them, their status and roles are similarly distinct.

The six sub-sections that follow explore these differences, and focus in turn on: the distribution of talk and silence; the initiation of topics, acts and tasks; interpretation and its dependence on shared knowledge; dentists' control strategies; mitigation and face-preserving activities, and the distribution of 'casual' and 'formal'speech.

To reiterate a point: the analysis is informal and non-technical, appropriately for a non-specialist linguistic audience. We hope, nevertheless, that it will serve as a preliminary indication of how relationships between participants in consultations are both maintained by and revealed through, use of language.

5:2:1: PROPORTION OF TALK AND SILENCE IN CONSULTATIONS

Consultation 1 takes place in the periodontic ward of a regional dental teaching hospital between a senior lecturer in Dentistry and a retired, male patient. The appointment is one of a series in a course of treatment to teach the patient how to clean his teeth properly so as to reduce plaque and improve the condition of his gums. The surgery setting is a small section in an open-plan department.

The attached transcript gives the timing of each utterance of the participants - dentist, patient and assistant - and the timing of silences. The numbers on the right-hand side are for ease of reference only. They roughly correspond to dentist, patient and assistant turns, each participant being numbered separately. Two seconds was the shortest silence noted. The figures in Table 6 indicate the duration and total number of utterances for the participants and the duration and total number of silences. The numbers are arranged on alternate lines where participants take turns or alternate with silences for action. If numbers are recorded on the same lines it means that two participants speak simultaneously, and a curly bracket { indicates that two or more utterances are subsumed totally in another participant's utterance. The stages in the progression of the consultation (outlined below in Table 5) are set alongside the utterance that initiates the stage.

Table 5 (SD = student dentist)

STAGE NO.	DESCRIPTION
1	greeting
2	elicit
3	recapitulation (of earlier consultations with representing patients)
4	inspection (including educate ⟶ P; instructions ⟶ D.S.A. inform ⟶ P; praise ⟶ P)
5	action-inform
6	explain / educate
7	prognosis
8	[P - initiate] elicit for information
9	injection (orginally projected by D between 5 & 6)
10	treatment work [D ⟷ SD consultation (elicit SD: instruct D) D ⟷ DSA exchange: comments P ⟷ D conversation (from D's topic), D elicits, encourages, 'directs']
11	prognosis (information on possible future treatment
12	D ⟷ DSA appointment-fixing D ⟶ P
13	leavetake

Table 6

STAGE OF ENCOUNTER	DENTIST	PATIENT	SILENCE	ASSISTANT
Greeting	10			
		1		
Elicit	10			
		.5		
	10			
		.5		
Recapitulation	4			
		.25		
	35			
		1		
	2			
		1		
Inspection	10			
			13	
	2	1		
	1			
			5	
	10			
			5	
	1.5			
			6	
	2			
			9	
	20	.5		
		.5		
			18	
	10			
		1.5		
	4			
			6	
	.5			
			11	
				7
	10			
				.5
	1.5			
				.5
	3.5			
				1
	2			
			9	
	10			
		.5		
	5			
			6	

Table 6 /continued

STAGE OF ENCOUNTER	DENTIST	PATIENT	SILENCE	ASSISTANT
	6			
		.5		
	1			
		2		
	6			
		.5		
	2			
			19	
	5			
			25	
Action-Inform (Education)	21			
		1		
	15			
		1		
	8			
		1		
	3			
		1		
	6	1		
		1		
	3	3		3
	.5			
				1
	3			
		2.5		
	13			
		1		
	3			
		2		
	.5			
		2		
	9			
		.5		
Prognosis: treatment	11	.5		
		1		
	1			
P elicit		8		
	1			
		1		
	1.5			
		1		
	1			
		1		
	1			

Table 6 /continued

STAGE OF ENCOUNTER	DENTIST	PATIENT	SILENCE	ASSISTANT
		.5		
	1			
		.25		
	2			
	.5	14		
	.5			
	5			
		2		
	4			
		.5		
	9	.25		
		2		
	3			
		1		
Injection	15			
			12	
	1			
			4	
	5	.25		
		1.5		
	10			
			5	
Treatment	15			
			23	
	24			
				3
	.5			
				.25
	1.5			
				.5
	1			
				1.5
	7			
				.5
	3			
			10	
	4			
			14	
	3			
			16	
	.5			
				1.5
	5			
				2
	7			
				.5
			9	

Table 6 /continued

STAGE OF ENCOUNTER	DENTIST	PATIENT	SILENCE	ASSISTANT
	2			
			26	
	1			
			4	
	1			
			7.5	
	2			
			20	
	3			
			10	
	8			
			14	
	5			
		3		
	1			
		1		
	1			
		.5		
	5			
		1		
	2			
		1		
	.5			
		.5		
	1.5			
		10		
	1			
		.5		
	12	.25		
		9		
	.5			
		2		
	3			
		2.5		
	.5			
		9		
	2			
		1		
	2			
	1.5	11		
	1			
	2			
		6		
	.5			
		2		
	.5			
		4		

Table 6 /continued

STAGE OF ENCOUNTER	DENTIST	PATIENT	SILENCE	ASSISTANT
	2			
		1		
	8			
		.25		
		.25		
		2		
	2			
		2		
	3			
		7		
	2.5			
		2		
	.5			
		4		
	1			
		1		
	20			
		.5		
		.5		
		5		
	3			
	.5	10		
		4		
	.5			
		3		
	2			
		2		
	3			
		3		
	1			
		2		
	1			
		1		
	5			
		1		
	15	1		
		1		
	1			
		.5		
	8			
		2		
	1			
		2		
	.5			
		4		
	2.5			
	1	5		
	9			

Table 6 /continued

STAGE OF ENCOUNTER	DENTIST	PATIENT	SILENCE	ASSISTANT
		2		
	1			
		4		
	1			
		3		
	.5			
		1.5		
	4			
		1		
	2			
	1	8		
	.5			
		.5		
		.5		
	1.5			
		.5		
Prognosis: next appointment	9	.25		
		1		
		1		
	3	4		
		2		
	1.5			
		1		
	2	.5		
	1.5			
	.5	3		
	6			
		1.5		
Arrange next appointment	18	.5		
		.5		
	3.5			
				.5
	5			
				1
	3			
				1
Leave-take	2			
		1.5		
	.5			
		.5		

Table 7 below shows the amount of silence and the amount of talk, as it is divided among the participants:

Table 7

	DENTIST	PATIENT	ASSISTANT	SILENCE
Secs.	638.5	233	25.25	308.5
%	50.9	19.6	2.1	25.3

The percentage line totals 97.9 per cent; the overlap of utterances between the participants therfore, is 2.1 per cent.

The amount of silence and the division of the amount of the talk between the participants can be diagrammed as follows:

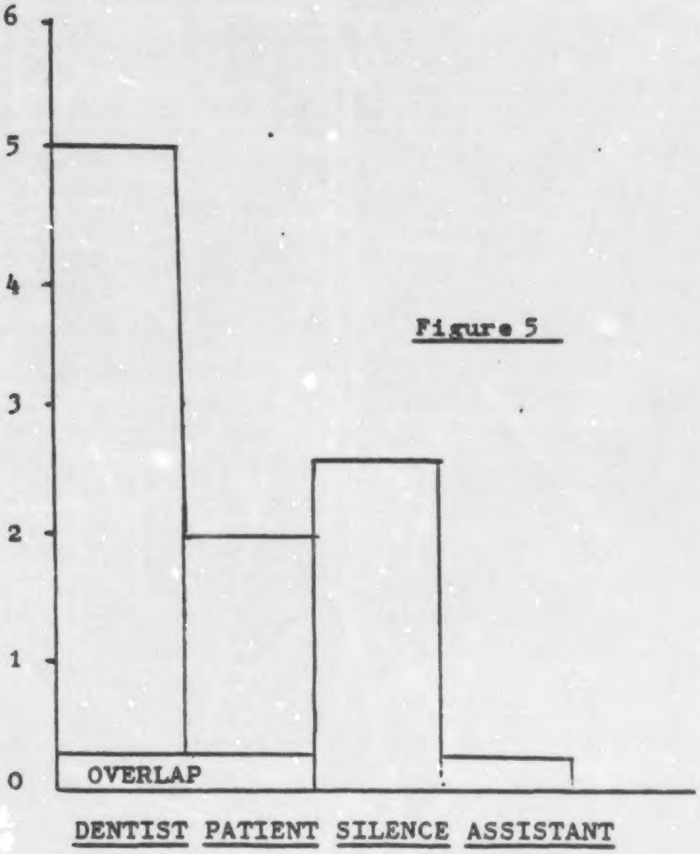


Figure 5

The dentist, then, does two and a half times as much talking as the patient, and silence takes up 5.7 per cent more of the appointment time than does the patient's talking. (The assistant, predictably in a hospital setting where assistants are not regularly attached to one dentist, took a very small proportion of the talking time). These statistics are especially interesting when both the dentist's and the observer's impressions immediately after recording the consultation were that there was more talk than normal between patient and dentist.

The longest silence recorded was 26 seconds. This is relatively short compared with other consultations below which contain silences of between one and two minutes. The longest dentist utterance recorded in this consultation lasts 35 seconds, the longest patient utterance lasts 14 seconds and the longest assistant's utterance lasts 7 seconds.

From this distribution of talk and silence we may deduce some evidence for assertions of dentist 'dominance' in consultations. (cf Bales 1970)

However when the proportion of talk between the participants and silence is looked at in terms of numbers of turns-at-talking and numbers of silences, evidence for this suggested dentist 'dominance' is not so overwhelming. Scrutiny of the data reveals that the patient makes a substantial number of initiating turns. The numbers in Table 8 below are taken from the figures in Table 6

Table 8

	DENTIST	PATIENT	ASSISTANT	TOTAL	SILENCE	TOTAL
Nos.	140	109	17	266	27	293
%	52.6	41	6.4	100	-	-
%	47.8	37.2	5.8	-	9.2	100

The numbers of silences and the divisions of the numbers of turns at talking between the participants can be diagrammed as follows:

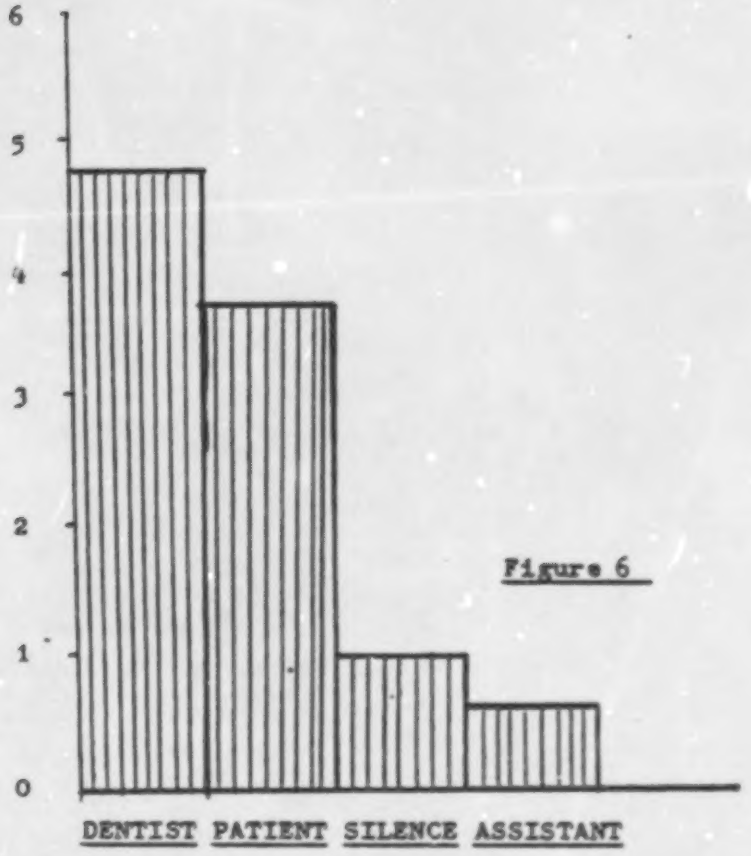


Figure 6

The number of overlaps have not been included in Table 8 and Figure 6 because some of the overlaps are successful bids for turns-at-talking and as such are represented in the appropriate columns in the participants' numbers of utterances.

It is now possible to compare in Figure 7 the amount of talk and silence with the numbers of silences and turns-at-talking as divided among the participants (represented separately in Figures 5 and 6).

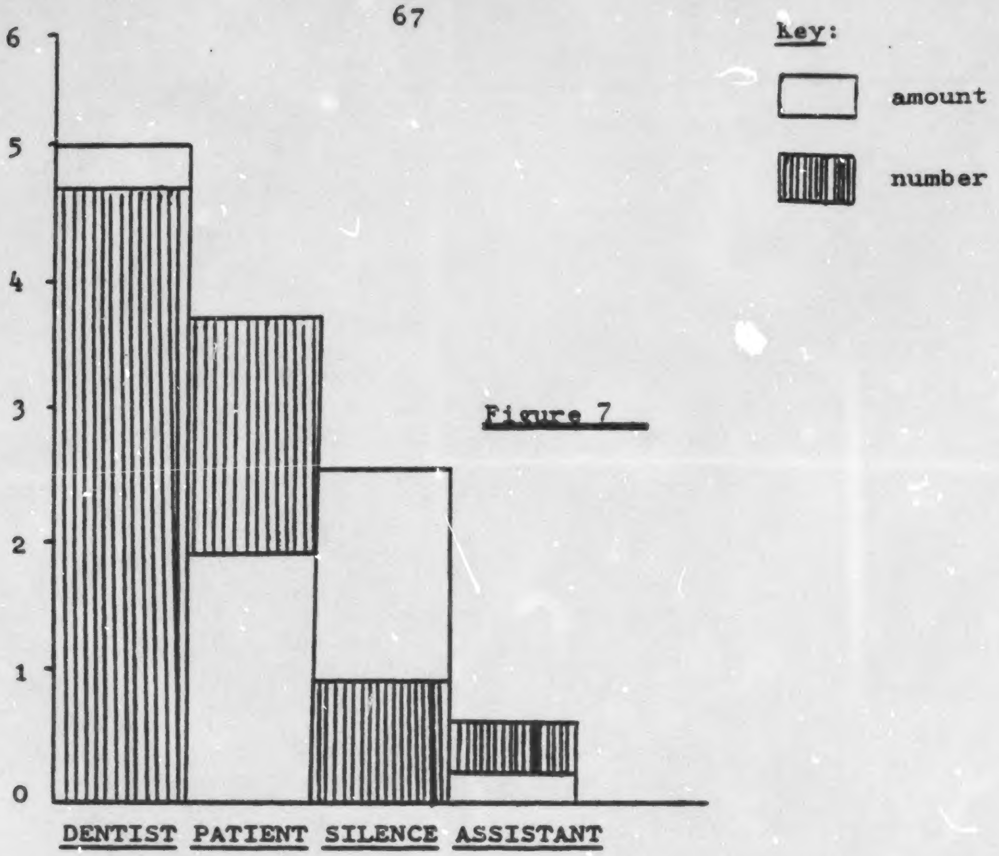


Figure 7

The comparison reveals that in terms of number of turns-at-talking the patient's and the assistant's participation in the consultation doubles. The occurrence of silence is more restricted than might have appeared from Figure 5. But in both analyses, the dentist dominates overall, even though Table 8 demonstrates that the total number of his utterances is less than half the total number of the interactions when the number of silences are included in the total.

Further evidence for the above assessment of the dentist's role is provided in Table 9 below where the average length of the participants' utterances has been calculated:

Table 9

PARTICIPANTS	NO. OF UTTERANCES	TOTAL SPEAKING TIME (mins.)	AVERAGE LENGTH OF UTTERANCE (seconds)
Dentist	140	10.1	4.3
Patient	109	3.88	2.1
Assistant	17	0.42	1.5

It is clear that an area that needs further investigation is the precise specification of initiating remarks. At some points, for example at the various stages of this consultation, there are clear initiations by the dentist (in itself additional evidence of his control of the activity if not of all the talk), as in D1 where the dentist requests information, possibly as a way of involving the patient in the activity.

Similarly with D2, 3, 4, 5 and 6, the dentist initiates what is said with requests for information, although D5 and 6 could also be seen as checking rather than requesting information. The dentist then initiates what is done next in D9, with a request demanding confirmation.

In D21 there is again a request demanding confirmation, which the patient acknowledges and elaborates in P12. The dentist was not perhaps expecting this patient turn because he attempts to continue in D22. P12 cannot be interpreted as an initiating remark because it is not responded to; it can only be interpreted as a response to D21. With P28, the patient successfully interrupts the dentist in D38 and because the dentist responds to P28 in D39, 40, 41, 42, 43, 44, 45 and 46, the patient successfully demonstrates that he has initiated a conversational topic. The dentist regains the initiative in D47 by referring to the topic, evaluating the situation, and by D50 he is in control of the conversation, and the activity. Furthermore, in Stage 10 (treatment), he is the only talker until D69 when he asks the patient a question after the work inside the patient's mouth has been finished and the patient is able to talk again.

Following this in P50 the patient volunteers information about himself and as the dentist accepts the information and shows interest in the information, we may conclude that the patient has successfully initiated another conversation. It is during this conversation, which continues virtually to the end of the consultation, starting 5.5 minutes before the end of the consultation (length: 19 minutes 50 seconds), that the patient contributes most of his talking. The patient's contribution is not concerned with dental treatment, and in any case a glance at Table 6 reveals that the patient does not dominate the event at this stage. His initiate P50 is not 'positive'-sounding (as for example, the dentist's initiate of D118) and is linked back to what he said before in P44.

A preliminary survey of the transcript shows that the number of back-channelling ~~remarks~~ 1 (Duncan S. 1979) of the dentist to the patient is approximately twice the number of similar remarks of the patient to the dentist. A plausible reason for this distribution is that the patient generally needs to be encouraged to talk in dental encounters and needs more evidence of dentist interest in what he is saying.

This preliminary investigation suggests we might look to whether dentists speak more slowly during parts of the encounter which they perceive as being important. Three utterances that are of a similar duration are subjected to a syllable count below, to see how many syllables the dentist says in a particular amount of time. The syllable divisions, marked on the transcript, were decided on the basis of listening to the audio-recording of the encounter.

Table 10

UTTERANCE (no.)	FUNCTION	DURATION (seconds)	SYLLABLES (no.)	SYLLABLES (per sec.)
D50	injection: explain	15	23	1.5
D54	instruction to DSA	15	34	2.3
D77	response to P in general conversation	12	53	4.4

Although it could be argued that D50 interacts with non-verbal activity, the fact that the dentist breaks down the turn into three moves(2) represents a deliberate slowing of the tempo of his speech. This kind of analysis could be extended.

The position of silences in this consultation indicates that silence occurs more often during stages of surgical or manual activity. Ten silences are recorded during the inspection stage and twelve are recorded during the treatment stage. Thus 22 out of the 27 silences recorded occur during non-verbal activity stages. It is interesting to speculate about the extent to which the talking that occurs in the other stages is the activity. Further analysis, based on video recordings, could reveal usefully and more clearly the interaction of verbal behaviour, non-verbal behaviour and silence.

Note 1: Back-channelling remarks are here defined as utterances which encourage the speaker to continue without interruption and examples include: yeah, mm, sure.

Note 2: By move we mean here those parts of a turn that can be distinguished functionally, though clearly this definition will need considerable modification in a more technical discussion.

Transcript

Stage 1
D : what we up to last time ((rustling papers)) is it D1
three months 10s

P : ((faintly)) [yes it is P1
1s
D : ((whispered)) good well now how are things Stage 2
[dentally they're okay D2
10s
P : [it's fine (   ) P2
0.5s

D : what about those uh loose teeth Stage 3
and so on are they still firm and so you're happy D3
with everything 10s

P : yes (   ) P3

0.5s
D : and you're still able to clean I see it was very D4
good wasn't it {before you got down to some six per 4s
P : {yes P4, 0.5s
cent and uh I think I was fairly amazed was I not
w - we were both fairly pleased anyway I won't D5
say amazed um ooh d- I threatened you with an 35s
extraction d'you remember early on that uh wisdom
tooth on the {lower right that's gone has it
P : {yeah I do P5, 1s

D : em we took that out for you did we D6, 2s
P : yes you did P6, 1s

D : righ - oh yes yes it's gone e-m good well let Stage 4
me have a look in see if the improvement has D7
been maintained 10s

SILENCE: 13s
D : now it was em an abscess that drove you along D8, 2s
wasn't it initially to your dentist {and then back to
P : SIL- {yes it was P7, 1s
D : {us (5s ENCE) and uh zzzrr zzzrr phew well now so we
P : {yes it was
were going to see whether we need to do much else D9
hey 's tilt you back (SILENCE: 5s) have a ride up 40s
(SILENCE: 6s) now let's have a look round cor

SILENCE: 9s

D : it's a little awkward getting round the back there D10
isn't it where we took that one out did we um show
you that little s- brush with the the- {tuft at
P : {mm P, 0.5s
right angles did we show an an in - interspace brush
please I'll show you one look you might find it D11
useful to um get round the back 'cos you there's 20s
a bit of a hollow still look down here isn't there

P : mm hm P8

0.5s

SILENCE: 18 s

{D : good now let's have a look on here just caught that D12
with you brush have you just {bit sore there 10s
P : {yes it is P9, 1.5s
a bit painful

D : you just caught that with the brush I D13
think your gum's a bit sore 4s

SILENCE: 6 s

D : hullo D, o.5s

SILENCE: 11s

A : (I've only got the little) head ('cause they've got A1
these) handles (and big) feet I've got you one of 7s
those as well ( )

D : you haven't ((laugh)) got a handle to go with it D14
it - it looks a little unreal doesn't it uh can I 10s
sorry can I have a loc - oh you're here now are you

A : yeah A2, 0.5s

D : can I have a local D15, 1.5s

A : yeah A3, 0.5s

D : with uh what do we have D16, 3.5s

A : ( ) A4, 1s

D : please and some curettes and hose D17, 2s

SILENCE: 9s

D : *well there's only* one area where there's some persistent inflammation of the gum that's on this uh big molar tooth here you feel where I am now D18-9 10s

P : mm hm P10, 0.5s

D : it's a bit rough under there but let's have a look at these turn towards me now D20 5s

SILENCE: 6s

D : hmph well they've tightened up a bit more haven't they they continu D21 6s
P : they have yeah P11, 0.5s
D : yeah they've continued D22, 1s
P : I don't feel any movement at all P12, 2s
D : no you're not aware of any looseness that is um that's very pleasing for you and D23 6s
P : no P13, 0.5s
you're keeping it very nice and clean D, 2s

SILENCE: 19s

D : is that decay in there ((whispered)) yep ah those things (probably another) ((sound of air jet being applied to teeth)) D24 5s

SILENCE: 25s

D : well that's fine um there's just one area on the top right there that I'd like to clean out thoroughly today like we did before you know em make you numb and j- sorry and just clean it all out mind the (wire) um so can I get on with that today Stage 5 D25 21s Stage 6

P : certainly P14, 1s

D : whilst you're going numb I'll show you this uh brush it's a bit unreal because there's a handle D26 15s

that goes on here right and we sell them in the big
machine over there uh you get three heads trouble is
it's sixty {pence
P : {that's alright P15, 1s

D : but you get three now can you see that there's a D27
little tuft at right angles imagine that if you 8s
will ((chuckle)) on the end of a handle right
P : yes P16, 1s

D : now that enables you to get round the back doesn't D28, 3s
it

P : oh yes P17, 1s

{D : {and you just use
{P : {(yes) P18, 1s

D : it with a jiggling action right you just poke it in D, 6s
and jiggle round d'you want to try that
P : yes P19, 1s

{D : {we've got them here you can lash out treat yourself D30, 3s
{P : {( ) P20, 3s
{A : {um A5, 0.5s
( ) used them ( ) all the sample ones

D : has she D31, 0.5s
A : gr I'll have a look A6, 1s

{D : just one with a handle I feel such a a fool holding D32
that little tip {back
{P : {well I can im- I can uh {visualise P21, 2.5s
it
D : {imagine, D33
right and eh eh any awkward nook and cranny you 13s
know you can get the (sides) well as your big brush
- cause you're doing very well now there's no need
to do anything with these teeth up here is there I
mean there's they're uh they're looking good they're
even firmer than they were before

P : oh yes P22, 1s

D : that's the sort of thing see that's it's a D34
different design 3s

P : oh yes I can see P23, 2s

D : right D35, 0.5s

P : it's fine well I'll pick one P24
of those {up on the way out you know 2s
D : {yes they're just there if you got - trouble D36
is with inflation you know you ha - need six ten 9s
pences don't you {the machine doesn't allow for inflation
P : {mmm P25, 0.5s

D : um there's no need to do further treatment up here Stage 7
they're fine the abscess the pockets have disappeared D37, 11s

P : no P26, 0.5s

D : you know the gaps between the gum and the tooth
that's fine I'm going to clean this one out on the
right and see how you go

P : good P27, 1s

D : {that's probab- D38, 1s
Stage 8
P : {I had a little accident with my little denture one P28, 8s
of the wires {broke off and I swallowed it {think I'll
D : {who {hmm D, 1s

P : come to any harm
P : ha ha P29, 1s

D : ((laughing)) no how long ago was it D39, 1.5s

P : oh it's hu P30, 1s

D : it's a while D40, 1s

P : couple of months ago P31, 1s

D : couple of months D41, 1s

P : hmm

D : now y- you're sure you swallowed it D42, 1s

P : mm P33, 0.25s

{ D : I mean {eh it broke in the mouth {and you {ate it D43, 2s
{ { P : {well I'm pretty {yeah {I was P34-37
{ biting on a- an {apple I think it was {actually 14s
{ D : {hum {yes D, 0.5s

P : it must uh

P : you know it curled under that tooth there and up and
around a weird sort of a thing

D : mm D, 0.25s

P : and uh I think the part that came around one tooth
was longer than the part inside and it must've ( )

D : and it was only the eh sort of the the wire bit was D45, 5s
it

{ P : mm there's a little bit of wire left on you {know P38, 2s
{ D : {yeah D46
so it was just no hunk of plastic or any rough 4s
P : mm P39, 0.5s

{ D : I'm quite sure that that uh th-that should be okay D47, 9s
{ but {um we can't afford to feed you as well as
{ P : {(well) P40, 0.25s

{ D : prepare your teeth {you know you can't {keep eating D48
{ P : {no no no {I'm short of P41, 2s

D : things

P : iron in me diet ha ha ha

D : I was going to say I mean we'll give you a few tablets if you want D49 3s

P : ha ha ha P42, 1s

D : ha ha ha let's/pop/a/li/ttle/lo/cal/in/the/-at/the/top/here/just/half/close/now/one/prick/up/here/that's/good/ D50: Stage 9 15s

SILENCE: 12s

D : well done D51, 1s

SILENCE: 4s

D : there we are best one you've ever had you have to to D52, 5s

P : yep P43, 0.25s

D : say that good

P : when are you gonna stick the needle in P, 1.5s

D : ((laughing)) again ha ha ha when are you going to do it yes now what's all this D53 10s

SILENCE: 5s

D : I/don't/think/we/need/those/that'll/on/ly/c'n/fuse/the/i/ssue/that/(Prep/dent)/brush/good/let's/tuck/that/in/round/there/well/it's/well/down/un/der/the/gum/now/ D54 15s

SILENCE: 23s

D : ((whispers)) (there's not we can have really)

D : they're not too numb on the other side I think but just just bear with it that's more that's worth having innit let's have a look ((whispered)) it's coming out (Miss D.) have you D55 29s

A : I have actually A7
got another patient ( ) at half three 3s
D : yeah yeah OK D56, 0.5s

A : uh A8, 0.25s

D : the what's the time quarter D57, 1.5s

A : quarter to four A9, 0.5s

D : yeah well have you done what you want to do D58, 1s

A : yes I've just done this very quick um A10, 1.5s
D : yeah what's this D59
this surgery three and possibly up there good that's 7s
fine uh you'll rebook it will you when I'm around
A : yes A11
yes OK 0.5s
D : away you go then make appointments D60, 3s

SILENCE: 10s

D : well I'm sure that's not very comfortable but we're D61, 4s

SILENCE: 14s

D : just a bit more now with these other things D62, 3s

SILENCE: 16s

D : hear that D63, 0.5s

A : noo ooh A12, 1.5s

D : ooh it's lovely that's what it's meant to be hee D64
hee hee hee 5s

A : ( ) (it crinkles) down the side it's horrible A13, 2s
ooh
D : that's what it's meant to be it's really nice and D65

D : clean now smooth squeaky clean 7s
A : mm mm A14, 0.5s

SILENCE: 9s

D : it's glassy hard that's what we want D66, 2s

SILENCE: 26s

D : right (1s) (SILENCE: 4s) there we are (1s) D67
(SILENCE: 7.5s) let's see what that's like now (2s)

SILENCE: 20s

D : just turn towards me a wee bit would you that's D68
good (SILENCE: 10s) there we are that's it let's 11s
give you a rinse away shall we

SILENCE: 14s

D : um have you seen your own dentist for fillings and D69
things lately or or what 5s

P : No I haven't um I haven't got a dentist actually P44, 3s

D : you haven't got a D70, 1s
P : not a regular checkup P45, 1s
D : you haven't D71, 1s

P : no P46, 0.5s

D : uh it's just that I notice there's a small hole in D72
one who did I write to Mr. Martin 5s

P : that's right yes P47, 1s

D : he was what you went along just the once did you D73, 2s
P : I just went along P48, 1s
yes
D : in trouble D74, 0.5s
P : yes P49, 0.5s

D : so he's not your regular bloke D75, 1.5s
P : no as I say I don't have P50
I I've not long come from the Canada and the States 10s
I been there for thirty year you know that's where
you should go with your looks and personality you'd
make a fortune

D : you think so D76, 1s

P : I reckon P51, 0.5s

SILENCE: 2s

D : can(t'/a)fford/it/ ((laughing))um/yes/one/hears/sto/ D77, 12s
ries/the/peo/ple/who/we/bought/the/house/from/'ve/just/
moved/out/t'Can/a/da/but/they're/not/den/tist/s he's/{a/
P : {mm P, 0.25s
D : sort/(of) arch/i/tect/so/pre/sum/a/bly/they're/a/land/
of/gol/den/o/ppor/tu/ni/ty/

P : well I think uh the state will have to see if it P52
(worked) first to believe it people can't understand 9s
just what it is like

D : mm ((loud crackling of paper)) D78, 0.5s

P : especially over on the west coast fabulous most jobs P53, 2s

D : mm yes what were you doing out there D79, 3s

P : well I'm an en- uh -s- civil engineer P54, 2.5s

D : yeah D80, 0.5s

P : and I went out there with the firm I was working for P55
who had a subsidiary there and uh I stayed 9s

D : you liked it mm D81, 2s

{P : {(fantastic) P56, 1s
{D : {were you with a big firm d'you stay with a big firm D82
{(that you were) staying with 2s
{P : {yeah I had with called (Holland, Hannen and Cubit) P57
who had a a a subsidiary company in Canada 11s
{called (Anglo-Moorcross) and we went uh in the {back
{D : {mm mm {very nice D83, 1s

{P : woods of Canada for quite a {while uh P58
{D : {yes yes D, 2s

P : then they got uh some contract in Buffalo in New P59
York State and that's how we got into the States 6s

D : hmm D84, 0.5s
P : and once we'd tasted it uh P60, 2s
D : mm D85, 0.5s
P : we stayed it's no P61
place for a loser 4s

{D : {yeah I'm that- that's one thing I'm aware of D86, 2s
{P : {it's a dreadful place to be poor P62, 1s

{D : yeah the comp- uh - yeah {that's right it's a D87, 3s
{P : {yeah P63, 0.25s

{D : sort of thing {and uh and so on but uh did you have D88, 3s
{P : {sure P64, 0.25s

D : family out there or were you are you
{D : mm thirty years you say {or thr D89, 2s
{P : {thirty years yes P65, 2s

{D : mm are you come back in retirement now are {you D90, 2s
{P : {came P66
back to retire {yes 2s
{tire where d'you live loc- just D91, 3s
nearby {or
P : {no I'm up in um a little village called P67
Halton village just by between Warrington and 7s
(Runcorn)

D : yeah well I don't {don't know the area yeah oh D92, 2.5s
P : {they made a new town like you know P68, 2s

D : hmm D93, 0.5s

P : you don't need your fare {yes well you don't have to P69, 4s
D : ((laugh)) {work your passage ha ha D94, 1s

P : pay a fortune get among the cattle mob hmm hmm hmm P70, 1s

D : there's a bloke here who just he's lived in Canada D95-96
at the moment he got a uh a s- travelling scholar- 20s
ship you know these sort of medical research councils
{and
P : {yeah P, 0.5s

D : things you know uh I thi- you know I'd be interested
to see what he says you know the the there's pros and
cons always {he's got a young family out there I think
P : {sure P71, 0.5s

P : but em as I say you have to see it to believe it 5s

D : yeah {oh I'd like to see it hmm hmm D97, 3s
P : {it's absolutely fantastic P72, 2s

P : I mean uh uh I would uh think that um the comparison 10s
between the the U.S.A. and Britain now is probably
uh {something like
D : {mm D, 0.5s

P : uh Britain today and Britain in 1850 P73, 4s

D : mm D98, 0.5s

P : Charles Dickens Britain {you know P74, 3s
D : {yeah Dickensian e mm D99, 2s

P : cor I dunno P75, 2s

D : well I {shall remember D100, 3s
P : {all my sons and daughters are there anyway so P76, 3s

D : are they D101, 1s

P : I came back because mummy wanted to come P77
back 2s

D : yes D102, 1s

P : well I think I'll {go back P78, 1s
D : {you left an hu the wh- they're D103
sort of got {reasonable job professional and this 5s
P : {got married there yes P79, 1s

D : and that mm

SILENCE: 2s

D : go west young {man I'll give it some serious thought D104
P : {( ) . yes P, 1s

D : I will honestly becau- it be interesting to see what 15s
this chap who's here who I've hardly met he's coming
back you know August having had a year out there
working over there not dentistry but doing sort of
dental science you know

P : yeah P80, 1s

D : for a year D105, 1s

P : mm P81, 0.5s

D : be interesting to see 'cause his circumstances are D106
very similar to my own you see sort of three or four 8s
young kids and that sort of thing ((rustling paper)) {mm
P : {go P82
out even if it's only for the children's sake 2s

D : yeah D107, 1s

P : marvellous out on the west coast P83, 2s

D : yeah D108, 0.5s

P : British Columbia a- uh and all the way down into P84, 4s
California beautiful place

D : they're ee they're always asking for dentists out D109
there and uh 2.5s
P : money money galore you're very very P85
highly paid I think you would quadruple your money 5s
D : yeah yeah yes D110
I'd be interested in the schools more you know 10s
'cause I I I like the sort of contact with patients
and then mucking around with students and so on half
of any time

P : it's all foundations there you know P86, 2s
D : yes all D, 1s
P : big boys you know support them but um P87, 4s
D : yeah hmm D111, 1s
P : ( ) no shortage of money no shortage of P88
anything 3s
D : hmm D112, 0.5s

P : if you've got the money to pay for it P89, 1.5s

D : I do you know I'd like to taste it I think I wouldn't D113
mind a year or so out there you know 4s
P : sure why not P90, 1s

D : well it would it would come out at this right time D114, 2s
P : that was wha uh that's what P91-93
we had in mind we we would go for uh a little while 8s
and
D : ('s tighten this up) D, 1s
P : then come back but the little while P92

D : thirty years D115, 0.5s

P : (for) thirty years ha ha P93

D : that's what we said about Liverpool we'll try you D116-7
know come up from the {South you see try Liverpool 6s
P : {yeah yeah P94, 1s

D : for a little while

P : yeah

D : you might get stuck you D118
never know look you need a new denture and you **Stage 10**
{need a filling 4s
P : {uh P95, 0.25s

D : so I'll see yer again hey D119
D : if you've got no uh regular chap is that {alright D120, 5s
P : {okay

D : shall I {do that it's a small filling do down there D121
P : {alright P97, 1s

D : is your denture wearable D122

P : oh sure yes {(   ) I see it's it it's down one side P98
D : {you se- yeah I see there's nothing I can D123

P : {a bit 4s
D : {do at the moment 3s
P : I don't think so no {y' see P99, 2s
D : {no you got it D124
with you or what 4.5s

P : yeah yeah (   ) P100, 1s

D : but you're managing with it just at the {moment and D125, 2s
P : {sure D101, 0.5s

D : I can book it in when I've got more {time to see D126, 1.5s
P : {mm see it was P102
{like that and it came up and along 3s
D : {yeah (D0.5s) mm yeah we might D127

D : be able to we can do something with that but it stays 6s
in for the moment
P : seems to hold up anyway P103, 1.5s

D : yeah alright now can I see em this patient when I **Stage 11**
got a bit more time on uh uh let me see uh next D128-9
Monday em can I see you on a Monday you're master 18s
of your own time now aren't you? I can see you in a
P : right P104, 0.5s

D : a week's time

P : yeah P105, 0.5s

D : uh Monday afternoon I've got a surgical booked right D130, 3.5s
A : mm mm A15, 1.5s

D : with Mr. B so don't book it in then but if D131
eh you know say three-thirty or something like that 5s
A : yeah A16, 1s
yeah

D : and just book it in when I've got a bit of time to D132
do a filling and so on 3s
A : right yeah sure A17, 1s
Stage 12
D : ( ) alright see you in a week's time okay D133, 2s
P : thank you 'bye 'bye P106
so much obliged to you 1.5s
Stage 13
D : righto D134
0.5s
P : 'bye P107, 0.5s

5:2:2: TOPICS, ACTS AND TASKS

[Note: In the accompanying transcript participant turns have been separately and consecutively numbered].

In any dentist-patient consultation it is possible to identify (at least) who initiates the topics being discussed, the communicative acts being performed and the treatment-related tasks being executed. This is the forms if this sample analysis and although it is possible from the data to assess the imbalance between dentist and patient turns-at-talking, we shall not refer specifically to matters of quantity and duration of turns.

In Table 11 the consultation stages are listed as they occur, with some brief description of the purpose of each stage.

More specifically, Table 12 attempts to list topics, acts and tasks as they occur. Topics are set in high case, tasks in lower case, and acts in lower case and underlined. Participants are listed in column two with the left-hand participant the initiator. Where two participants are listed as D ⟷ P, with the double arrow indicating an exchange, the position of D on the left (in this case) indicates that it is he who initiates the topic, act or task.

Table10

STAGE NO.	DESCRIPTION
1	fitting mikes
2	check {previous treatment need for injection:
3	drilling and chat D ⟶ P
4	treatment [D ⟷ DSA: treatment assistance explanations D ⟷ DSA: next P P ⟷ D]
5	prognosis: how to treat condition
6	polish (while filling sets) D ⟷ DSA: phone-call P ⟷ D D ⟶ change topic ⟶ holidays
7	denture-fitting & drilling & practice fitting for P
8	Begin terminate (P ⟶)
9	Leave-take

Table 11

STAGE	INITIATOR	TOPIC, ACTS & TASKS	TURN NO.
1	D ⟷ P	RECORDING OF CONSULTATION	1-2
2		PURPOSE OF VISIT: FILLINGS AND INJECTION	3-7
			8-9
		INJECTION	10
3		BEGINNING: TO DRILL & PROCEDURE	11-12
			13-14
		CHECK OK FOR P	15-18
		P's TRIP TO SCOTLAND	19-20
		P's WORK	21
		APPOINTMENT PROCEDURE	22-23
4	D ⟷ A	instruct	24-25

/continued

STAGE	INITIATOR	TOPIC, ACTS & TASKS	TURN NO.
	D ←→ P	P check	26
	D ←→ A	instruct	27
	D ←→ P	instruct	28
	P ←→ D	SUCCESS OF CROWN TREATMENT	P10, D29 30
	D ←→ DSA	instruct	31
	D ←→ P	RECORDING EQUIPMENT	32-35
		instruct	36
	D ←→ DSA	admin, check	37-39
	D ←→ P	inform	40
	D ←→ DSA	instruct	41
	D ←→ P	instruct	42-43
	P ←→ D	elicit: FILLING COMPOSITION	P12-18
	D ←→ P	inform: FILLING COMPOSITION	50-55
5		instruct	56-58
6		instruct	59-60
		inform	61
	D ←→ DSA	admin, inform	62-63
	P ←→ D	D's INFLUENZA	P21
		D's CAR PARKING	P22
	D ←→ P	NEW SURGERY COLOUR	68
		instruct	69-70
	D ←→ DSA	instruct	71
	P ←→ D	elicit: TOOTH BLEEDING	P24
		inform: GINGIVITIS	P26
	D ←→ P	P's TRIP TO SCOTLAND	75
	P ←→ D	PUMPS	P28
		ENGINEERS	P29
		AMOUNT OF WORK	P30-32
7	D ←→ P	inform	79-80
	P ←→ D	MIDDLE EAST WORK OPPORTUNITIES	P33-35
	D ←→ P	MIDDLE EAST NON-ALCOHOLIC COCKTAILS	83-84
	P ←→ D	INDONESIA	P37
	D ←→ P	instruct & evaluate treatment	85-86
	P ←→ D	evaluate treatment	P39
	D ←→ P	evaluate treatment	89-93
	P ←→ D	evaluate treatment	P42
8		checks treatment	P43
		RECORDING EQUIPMENT & TV	P45-46
		thanks & leave-taking	P47-48
	D ←→ P		100-103
	A ←→ D	leave-take	A9
	D ←→ A		104-105
9	P ←→ D	leave-take	P52

This table outlines the following information concerning who initiates most topics and acts and how often:

Table 12

INITIATOR	TO WHOM	TOPIC, ACT, INITIATES (no.)	%
D	P	26	50 65.4
D	A	8	15.4
P	D	17	32.7
A	D	1	1.9

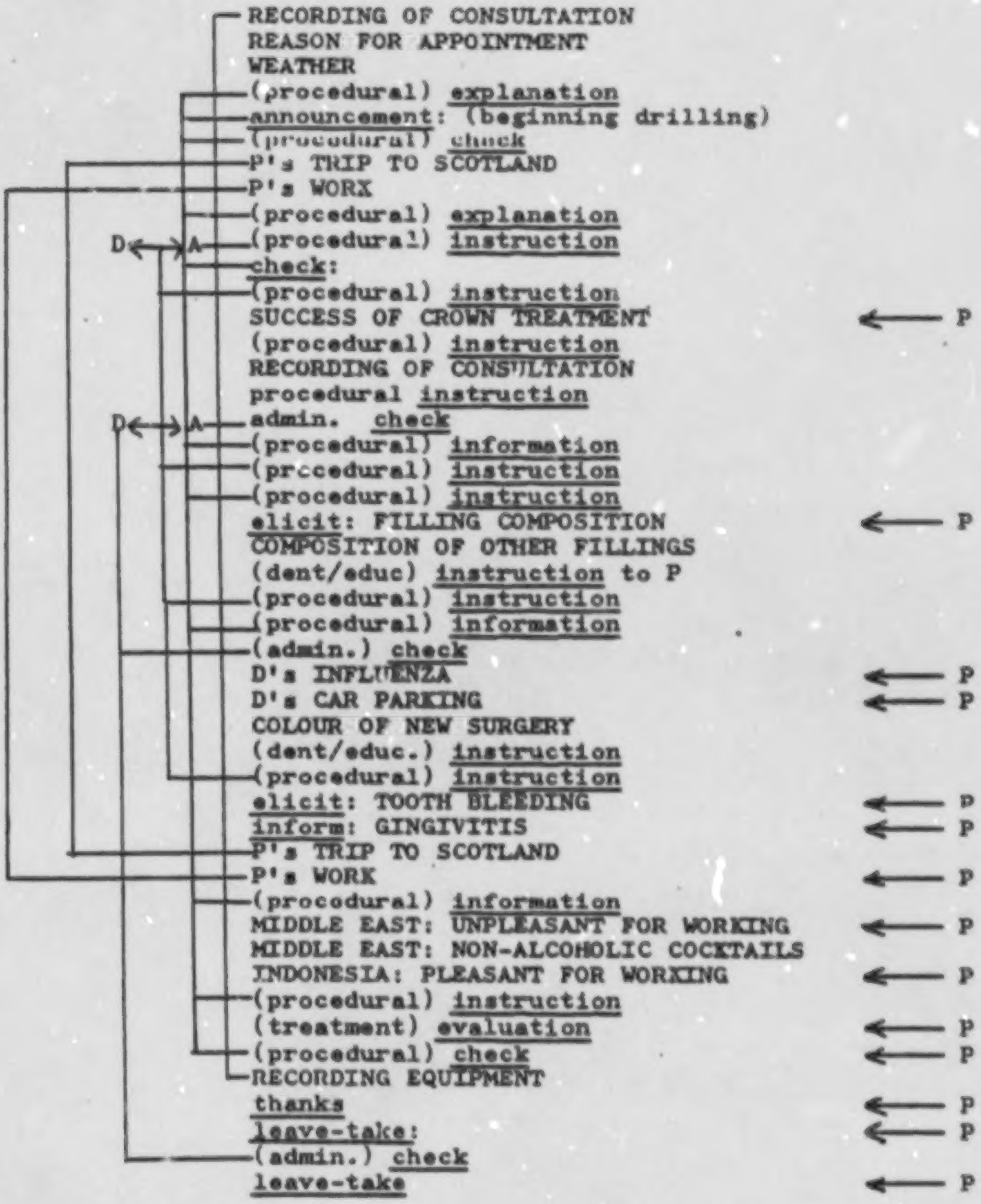
The dentist clearly initiates the most, 65.4 per cent, of all topics acts and tasks.

Table 13 below indicates how often topics and acts are re-introduced. Topics and acts initiated or re-initiated by the dentist are indicated in the first column and those by the patient in the third column.

Table 14 which follows Table 13 summarises the total number of topics and acts and who initiates them. The stages of the consultation are in the first column and column 2 indicates the initiator of the activity stage as well as the topic and act.

The patient tries to initiate eleven of the twenty topics and acts, but Table 11 shows that the dentist actually has more turns, that more of his initiates are successful, and that more of his initiates concern the patient's dental problems (treatment or advice) than do the patient's. The patient 'tries' more initiates because he is seeking a conversation that will interest the dentist. His initiates are more tentative than the dentist's,

Table 13



RECORDING OF CONSULTATION
REASON FOR APPOINTMENT
WEATHER
(procedural) explanation
announcement: (beginning drilling)
(procedural) check
P's TRIP TO SCOTLAND
P's WORK
(procedural) explanation
(procedural) instruction
check:
(procedural) instruction
SUCCESS OF CROWN TREATMENT ← P
(procedural) instruction
RECORDING OF CONSULTATION
procedural instruction
admin. check
(procedural) information
(procedural) instruction
(procedural) instruction
elicit: FILLING COMPOSITION ← P
COMPOSITION OF OTHER FILLINGS
(dent/educ) instruction to P
(procedural) instruction
(procedural) information
(admin.) check
D's INFLUENZA ← P
D's CAR PARKING ← P
COLOUR OF NEW SURGERY
(dent/educ.) instruction
(procedural) instruction
elicit: TOOTH BLEEDING ← P
inform: GINGIVITIS ← P
P's TRIP TO SCOTLAND
P's WORK ← P
(procedural) information
MIDDLE EAST: UNPLEASANT FOR WORKING ← P
MIDDLE EAST: NON-ALCOHOLIC COCKTAILS
INDONESIA: PLEASANT FOR WORKING ← P
(procedural) instruction
(treatment) evaluation ← P
(procedural) check ← P
RECORDING EQUIPMENT
thanks ← P
leave-take: ← P
(admin.) check
leave-take ← P

Table 14

STAGE	INITIATOR:	TOPIC
	D	RECORDING OF CONSULTATION
1	D	REASON FOR APPOINTMENT
	D	WEATHER
2	D	(procedural)
	D	P'S TRIP TO SCOTLAND
	P	P'S WORK
3	P	SUCCESS OF CROWN TREATMENT
4	D	(admin.)
5	P	COMPOSITION OF FILLINGS
6	D	ADVICE TO P ON HOW TO TREAT TOOTH
	P	D'S INFLUENZA
	P	D'S CAR PARKING
	D	COLOUR OF NEW SURGERY
7	P	TOOTH BLEEDING GINGIVITIS
	P	MIDDLE EAST
	P	INDONESIA
8	P	(evaluation of treatment)
	P	(thanks)
	D	(leave-taking)
9		(leave-taking)

for example P12 and 13, and P24. The consultation is unusual in that the patient initiates Stages 7 and 8. Stage 7 is an extra stage inserted because the patient requests information of the dentist. The patient at Stage 8 tries to initiate the termination of the consultation in P43 but does not succeed in terminating it until P52 because the dentist initiates a further leave-taking sequence in D100. The attempt shows perhaps that the patient is more relaxed towards the end of the consultation. Once the surgical or manual treatment is completed the patient may be more inclined to initiate conversation or to attempt to direct the flow of the activity.

After both P21 and 22 in which the patient attempts to draw the dentist into conversation, the dentist gives detailed answers. He does not, however, extend either topic initiated by the patient with follow-up turns which demand further responses from the patient on the topics. Following a pause after D67, D68 introduces a different topic which is connected with D65.

The dentist re-initiates a topic in D75 and engages the patient in conversation on it for several turns, allows it to lapse after P32, and then re-initiates conversation on the patient's dental problem in D79. Similarly, after a topic initiated by the patient in P33 and continued to P37, there is a silence while treatment continues. The dentist talks next about that topic, in D85 and the patient does not say much again (apart from one turn, P39) until after D91.

Whereas the patient's initiates appear tentative, the dentist's by comparison do not, particularly in the early stages of the consultation. D4 assumes for example, that the patient will want an injection. The patient's response in P1 is hesitant. To do justice to the dentist's sensitivity, however, he realises by D5 that he has made a wrong assumption. The dentist initiates *Stage 3* (D11) with an *inform* to the patient and *Stage 4* with an *instruct* to the assistant. This latter acts as an *inform* of some kind to the patient in D24, *Stage 5* in D56 with an *instruct/inform*, *Stage 6* similarly with D59. By contrast the patient's initiate of *Stage 8* in P43 is a *request* demanding a yes/no answer followed by a condition.

Some evidence of the interaction of non-verbal with verbal behaviour is provided by P12. This is a comment on what the dentist has just been using for a filling for the patient's tooth. *This* does not refer to any word or phrase in previous turns, it obviously refers to filling on display; *it* in D56 is a similar example, as is *fine* in D59.

In D56-58, the talk is the activity, specifically, advice, dental-education and history-taking. These are stages where talking is the dominant activity, supplemented where necessary, by action. The dentist's *instructs*, for example, D36, 42, 43, 69 and 70 interact with the non-verbal activity in that they initiate or prohibit further action.

In Stage 3, a work stage (drilling), the dentist introduces general conversational topics to relax and distract the patient from the drilling, but in work stages 6 and 7, the patient has the opportunity for further talk. It is here that the majority of the patient initiates are made, at a time when the dentist is still preoccupied with work. The topics initiated in Stages 1, 2, 3 and 5 predominantly concern work, with the exception of D19-21, which we see as being intended to aid the patient's relaxation, and to that extent *do* contribute to the treatment.

Taken together with other factors, such as the participants' different amounts of talk and numbers of turns, we can explain the patient's initiation of more topics than the dentist as implying a series of unsuccessful bids to influence the direction of the conversation. Although this consultation is a particularly good example, it does indicate how extra-dental topics are to be seen primarily as distractors from the work at hand rather than as serious opportunities for extended patient-initiated and controlled talk.

Transcript

D : yes um every word is noted any rash promises you make are recorded and I'll just if you permit me to pin that little microphone on oh yeah your collar D1 Stage 1

P : yeah

D : there (   )

P : (   ) yeah

D : they won't miss a syllable then see ((laugh)) D2

P : ((laugh)) no

D : er couple of fillings er you you like a wee injection D3
if we're going to start pottering about with fillings
and things

P : pardon

D : you like a wee injection if we're going to potter D4
about with fillings and things James you said you like
it numbed up for fillings

P : well I I normally d I've only had one injection for P1
fillings normally ( )
D : you normally manage without D5

P : well I bet for that one that I injected that for he P2
had one of those er root treatment things you know
D : yeah yeah D6
you prefer to do without the injection yes
P : well normally I do P3
I don't mind a bit of a little pain

D : yes well let's try it then if it's at all tender D7
then you want me to freeze it then I'll do ( )
P : okay

D : we'll woon get a little injection in
P : will do

D : getting a bit duller now James isn't it but it started D8
off brighter than it is now

P : it could be quite pleasant last week mm P4

D : oh yes some nice days D9

SILENCE

D : well if you do want me to stop when I'm working D10
James just touch your chin I'll stop immediately
if you [do that starting roud you mouth on the [left Stage 3
P : [mm mmm [mm

D : hand side now starting now

SILENCE

D : you'd like to rinse out [now for me James D12
P : [yup thank you will do

D : that's okay just that little (wire there) D13

P : ((laughs))

D : throw it a bit forward will you D14

SILENCE

P : okay fine

D : are you managing ( ) yes that'll be alright D15
P : oh yes( ) mm

D : starting round again D16

SILENCE

D : you're getting a little bit of water in your mouth D17
now James [( )
P : [( )

SILENCE

D : and wash again D18

P : mmm

D : did you say you were going up to Scotland last D19
time I saw you

P : pardon

D : did you say you were going up to Scotland last D20
time I saw you

P : yeah no um

SILENCE

P : probably may be going for about a fortnight's time I P5
think ( ) Glasgow
D : ( ) yes whereabouts are you D21

P : well I have to see a firm you see I I I'm supposed
to go out to Malaya in October P7

D : oh

SILENCE

P : not going out for long only for 4 weeks I think P8

D : yes er little bit of work on the front tooth now D22
James

P : mmm

SILENCE

D : and rinse again for me D23
P : thank you

Stage 4

D : could we have 4 amalgams please Vicky and give me a D24
A : . yeah

D : little bit of cement

D : thick

A : first A1

D : yes please and I want the adaptor as well D25

P : thank you very much for that about that D9

D : comfortable D26

P : oh yes

SILENCE

A : and adapt for one A2

D : for one

SILENCE

D : can I have tissue please D27

{ D : {Vicky just rinse again {James D28
{ P : {thank you yup {yes

D : thank you

SILENCE

{ P : this crown's been no trouble {at all so marvellous P10
{ D : {that's good so D29
everything's settling in alright so you're quite
happy with it

{ D : there's it's better that than just bunging another D30
filling in {(   ) it should
{ P : {oh yeah yeah

{ D : fit you for a few weeks {(   ) but I think you'll
{ P : {mmm ((laugh))

D : find that the crown'll do

P : mm

D : it'll be in a year or a lot longer

SILENCE

D : good thank you and ready for the amalgam now D31

SILENCE

D : falling apart here D32

P : pardon P11

D : we're falling apart here D33

P : oh

D : they'll miss some of the utterances D34

P : ((laughs))

D : we can't have that D35

SILENCE

D : I must put a a little clip thing on to your tooth it D36
looks a little bit fiendish but really it's quite
harmless it's just to support the filling whilst
I'm building it up you know {it forms a wall to the
P : {oh yeah yeah

D : tooth and the cavity's sizeable

P : hmm

SILENCE

D : check up next door is it ( ) D37
A : ( ) and then some ( ) A3
results

D : thank you

A : and I think this um A4

D : just for a check up with and er Chris Townsend D38
A : Chris Townsend yeah yeah
Mrs. Wolstenholme A5

D : ( )
A : yeah someone's just found them A6

D : the trouble starts if one doesn't come you get two D39
or three

A : mm

D : just put this filling in for you now James D40

P : mm

SILENCE

D : thank you (adaptic) please D41

SILENCE

D : now take that clip out and if you rinse these bits D42
away they're annoying back of your mouth after just
P : mm

D : let me take this away

D : don't bite your teeth together yet James well have D43
a good rinse round get rid of all those bits and pieces
P : pardon

P : this this this actually is that stuff with a magnum isn't it this filling P12

D : it's it's what James sorry D44

{ P : do they call it the magnum do {they P13
{ D : {no amalgam D45

{ P : amalgam {amalgam amalgam that's it P14
{ D : {amalgam that's what it is yes D46

SILENCE

P : it has a metal base I take it then P15

D : it it's all met it's really it's er a solution in mercury if you like to think a supersaturated solution and the alloy is basically a silver alloy D47

P : mm the other one is more of a sort of cementy base what (do they) call the other stuff then P16

D : silicate D48

P : pardon P17

{ D : silicate {silica phosphate cements yes D49
{ P : {silicate P18

D : but the one we were using at the front is um in fact even better than that 'cause it's one of those modern composite resins D50

P : mm

{ D : it wears much better {much much better {looks a lot D51
{ P : {yup {mm

D : it's er it's almost as strong as this metal filling D52
at the back 'cause it has an additional factor
P : (   )

SILENCE

D : that's made by Johnson and Johnson D53

P : oh ((laugh)) good firm P19

D : yeah baby's bottom people D54

SILENCE

D : if it's good enough for (a) baby's bottom it's good D55
enough for me

P : mm

SILENCE

Stage 5

D : try not to bite on it for a bit James this this stuff D56
sets you know in a matter of minutes but it sort of
toughens up a little bit it sort of matures if you like
P : mmm

P : mmm

D : er and if you just um keep well away from 'em it'll D57
do better

P : mm

D : rather than if you just champ away happily after a D58
couple of hours

SILENCE

D : fine (   ) thank you just keep open if you want D59
James whilst that stays like that I'll carry on
P : mm

D : pottering about (   )

P : mm

D : whilst it sets

SILENCE

Stage 6

D : well give it a good rinse out there D61
P : alright

D : James and we'll give it a bit of a polish up D60
P : mm thats fine P20

SILENCE

D : did you ring that (   ) Vick D62

A : mm A7

D : smashing did he bring it up D63
A : no they haven't got it A8

D : good

SILENCE

D : now (   )
P : you've had you've had influenza P21

D : yes I had a wee bout at er D64
P : ((laughs))

D : well it wasn't so much em p quite happy to work but D65
I don't like to sort of you know hang over people
and and you know breathe in their faces so I took
P : yeah yeah

D : a day off yesterday well it wasn't off I was upstairs
doing paperwork you know but um

P : you're not having any trouble with parking your land rover then are you P22

D : no well I'm in so early these days 'cause we've got a new cleaner and she hasn't got a key yet you know so she uses my key so I have to come in at seven o'clock to let her in and at that time of the morning there's no problems with parking you know D66

P : yeah

D : I should think it'll deteriorate though as the season wears on D67

SILENCE

D : did I tell you we've decided to paint it black and white stripes D68

P : oh I see for the children P23

{D : yes {((laughs))
{P :   {yes ((laughs))

SILENCE

D : stretch very wide for me James D69

P : mmm

SILENCE

D : now if you just wash that paste D71
D : out can we have some more mouth wash please Vicky D70

P : thank you

SILENCE

P : I suppose er when you know when you um clean them with that er less abrasive thing they may do this ought to um bleed a little should they P24

D : yes yes y you when you go along the edge of the gum D72
that's where you find in the the gingival crevice
P : yup

D : that's where most of the stuff's there and when you
P : yep

D : go along there and give them a bit of a scrub they D73
do do tend to get the gums bleeding um they don't
bleed at home whenever you're brushing your teeth
normally do they no that's alright that's the main
P : no no P25

D : thing yeah it's quite alright for them to bleed
with that that's no problem
P : I once had that is it gingivitis they P26
they call it I once had that and er that was in
D : yes yes yes

P : the service you had that of course
D : yes once once you've had it D74
you you're forever prone to get a recurrence of it
you know so that if you've ever had it once then
P : mm

D : obviously you've done a good job of looking after
your teeth since then because you have an increased
P : mm

D : liability to suffer it again

P : mm

D : and how long are you going to Glasgow for D75

P : oh I should say about a week (P27) and they're P28
waiting um they're going to get all the pumps
from there and take them out to the Far East and then
of course I shall (   ) parts for the pumps actually
D : pumps was it wears D76
are going to do

P : no no they're made in ah ah Birmingham I think P29
Beresfords but but
D : it no ah

P : some of the engineers of course are from Glasgow
D : oh I see
they seem to have
P : it's only job I have so far er I I've P30
got a little work I think to do I may have a job
before I go out there I'm on my own now you know
D : yes
are you oh I didn't realise that D78
P : oh yes

P : I've just had a little work on you see not very P31
much really but one can't complain we live very P32
well in this country so they can't complain here really
D : no no quite

SILENCE

Stage 7

D : er I'm trying to adjust this so that it's comfortable D77
enough to get in but it's firm when it goes there
you know

P : mm

D : and I think it's going to be rather tight on the D80
right hand James

SILENCE

P : there's plenty of work you know um in in the Middle P33
East but I I wouldn't go to the Middle East

D : why not P81
P : well I I um wouldn't like to work there there P34
at all because too far too many restrictions
assumed when you go there

D : far too many restrictions D82

{P : oh {yes I mean you well I don't drink heavily anyhow P35
{D : {yes

P : but I don't smoke but I mean the whole thing has
been strictly put on you they say in other words if
you wanted a a bottle of wine or something you couldn't
have it it's not there for you

D : that's right but don't they have non-alcoholic er D83
aperitifs

{P : oh I don't {know well I would{n't go there P36
{D : {no {no

D : and the way things are going just now D84
P : ( ) one place P37
I'd like to go to is Indonesia I'd like to go there

D : uhuh

SILENCE

{D : just rest your head back {again James we'll try this D85
{P : {yup

D : again

SILENCE

D : oh that's much better there D86

P : mm P38

D : wants a little shade at the front there nothing D87
very much the trick is to get it comfortable you
P : mm

D : know without it being slack

P : sort of bedded pretty well though hasn't it P39

D : oh yes yes

SILENCE

D : it's just that if we can leave it so tight that it's D88
a bit of a panic to get the thing in and out and

P : mm

D : there's nothing less pleasant than having something
in your mouth that won't shift

P : mm

D : so you see it pops in and out with a little snap and D89
um well just try and see how you go on do you could D90
you just close together for me here and just let me
see how you are when you close together be a little
strange

P : mm

D : of course you'll feel that your old denture and what D91
not if I let you just rinse out any wee bits up
there and then perhaps you have a crack at taking
the thing out yourself and we'll see if it's er you
know it's easy enough for you

P : mm

SILENCE

P : well that's okay I think P40
D : yes that's a wee bit (D92) just let me see it before D93
you put it back in again

P : pardon P41

P : they're very small P42
D : yes try that again putting it in D94
yourself that's it quite easy quite comfortable are
P : mmm yep yep yep

D : they James feel quite happy fine

D : that's OK

Stage 8

P : well that's all now isn't it I can clean them now and P43
D : that's it that's D96
it yes indeed um

P : thank you

SILENCE

P : fine P44

D : thank you ((laughs))

D : a star of stage off now ((laughs)) D97

P : I suppose this is what they have when they're in P45
front of the television cameras (   ) got the makeup P46
D : it's almost the same D98
sort of thing yes ((laughs))

P : thank you very much indeed (47) I'll just get you some P48
D : not at all thanks D99
please if you're at all bothered um D100

P : what P49

D : if you're at all bothered by anything about them just D101
pop in here you know um we don't mind particularly when
you're going abroad for a bit you know pop in if there's
any troubles at all and um she'll give you a six D102
month check up form downstairs if you want

P : that's okay P50

D : um but if there's any problems before then you know D103
you're welcome upstairs
P : of of course yes yes P51

A : didn't find those green pills on the shelf A9

D : oh

A : ( ) A10

D : did you get in touch with ( ) no okay ( ) yeah I'll D104
A : no no A11

D : check upstairs with her but she'll think you have
it alright D105

A : can't find it A12

Stage 9

P : right well good bye P52

D : okay good bye D106
A : good bye A13

5:2:3: INTERPRETATION AND SHARED KNOWLEDGE

The consultation discussed here is particularly interesting because it takes place within a more limited frame of discourse, that of a dental examination, and in it the dentist has an openly directive role. However it appears that what the dentist wants to know about the patient and why he wants to know it are not made explicitly clear to the patient. Table 15 shows the activity stages of the consultation. Each stage of the consultation was divided into episodes and with each episode, the functions of each turn were defined, revealing a functional sequence to the whole consultation. This preliminary analysis is laid out below in Table 16. The episodes set out in it are also labelled on the Transcript.

Table 15

STAGE	DESCRIPTION
1	Greeting
2	elicit P's reason for coming
3	history-taking
4	inspection
5	administration D ⟷ A
6	inform P of prognosis
7	leavetake: P sent for X-ray (P will return for diagnosis)

The only episode that the dentist does not initiate in this consultation is the last, Stage 7 which the assistant initiates on behalf of the dentist. A point that has been raised above occurs again in the analysis of this consultation: even though the patient makes 30 of the 84 moves, (35.7%), the length of them is very short compared with the duration of the dentist's moves.

The labelling of the different kinds of moves, such as request x, give x, have been developed from Labov W and Fanshel D (1977) and are explained in the key with Table 16 below.

Table 16

STAGE	EPISODE (1)	EPISODE (2)	EPISODE (3)
1	D1 greet		
2	D2 request x P1 give x P2 volunteer D3 request 2x P3 give 2x D4 request 3x P4 give 3x D5 confirm	D6 request Y/N1 P5 give Y D7 acknowledge D8 request 4x D6 give 4x	D9 request Y/N2 P6 restate P7 give N D10 request Y/NB P8 give N D11 check D12 acknowledge*
aim of episode	gives general problem: abscess, position, duration	pain	probe
3	EPISODE (4)	EPISODE (5)	EPISODE (6)
	D13 state intent P9 acknowledge D14 check	D15 request Y/N4 P10 give N D16 request Y/N5 P11 give N D17 request Y/N6 P12 give Y+ D18 request Y/N7 P13 give N D19 request Y/N8 P14 give N D20 request Y/N9 & acknowledge P10 P15 give N D21 check D22 request Y/N10 P16 give N D23 request Y/N11 & 12* D24 request Y/N13, 14, 15 P17 give N(3) D25 confirm D26 request Y/N16 P18 give N	D27 request Y/N17 P19 give N: D28 request 5x P20 give 5x D29 request 6x P21 give 6x D30 request 7x P22 give 7x D31 frame
aim of episode	focus/frame	history-taking	check dental history

Table 16 /continued

STAGE	EPISODE (7)	EPISODE (8)	EPISODE (9)	STAGE
4	D32 frame D33 request/ instruct P23 accept D34 thank D35 instruct D36 evaluate D37 frame	D38 instruct P24 accept D39 check D40 request Y/N18 P25 give Y D41 confirm D42 frame	D43 request 8x A1 request 1x D44 give 1x D45 give 2x	5
	set up inspection	inspection	admin. D A	
6	D46 frame D47 give 3x P26 acknowledge D48 give 4x D49 check P27 confirm D50 instruct/ inform P28 acknowledge	A2 suggest/ instruct P29 accept A3 check P30 thanks A4 frame	7	
	inform P of prognosis	leave-take		
	EPISODE (10)	EPISODE (11)	STAGE	

KEY:

Request x = request information
Give x = give information
Request Y/N = request yes/no answer
Give Y = give yes answer
Give N = give no answer
Give Y+ = give yes answer and volunteer extra information
* = paralinguistic response

From Table17 below it can be seen that 60% of the moves are concerned with requests for information and the informing responses to these requests. The table indicates a near-even split between the two main participants; it should be noted that of the total number of the patient's moves in the encounter (30),

Table 17

PARTICIPANT	DESCRIPTION OF MOVE	NUMBER	% OF TOTAL
D	requests x	8 (incl. 1 to A)	30.9%
D	requests Y/N	18	
		26	60%
P	gives x	7	30%
P	gives Y/N	16	
P	gives Y/N+	2	
		25	

18 are monosyllabic. It is worth emphasising that 68% of the dentist's requests are of the form: request Y/N. requests of this form may be said (Labov W, Fanshel D 1977) to contribute to the 'dominance' of the initiator (the dentist) because they request specific answers - affirmation or negation - whereas requests of the form: request x, request an 'unknown' answer. Note also that four of the dentist's moves are framing moves (compared with none of the patient's) i.e. 4.8% of the total moves. One of the assistant's four moves is also a framing move, and as remarked above, she is probably in this acting as a surrogate dentist. In all stages of the encounter, the dentist makes the greatest number of moves; a particular example is the inspection stage (4) where the ratio of dentist to patient moves is 11:3, i.e., 78.5%:21.5%. Although the patient volunteers information in P2 and 7 and 12, the volunteered information is relevant and may be said to demonstrate patient compliance.

The transcript has another significant variation from earlier Transcripts (cf 5:2:1: and 5:2:2: above) it has been expanded to make explicit the 'buried' data. The 'buried' data is typed in capitals and is in square brackets, and represents, of course, a plausible (but not certain) gloss by the analysis. The Figures, 8 - 11 that follow show the underlying chaining between moves and make explicit the implicit references.

Figure 8 : stage 2

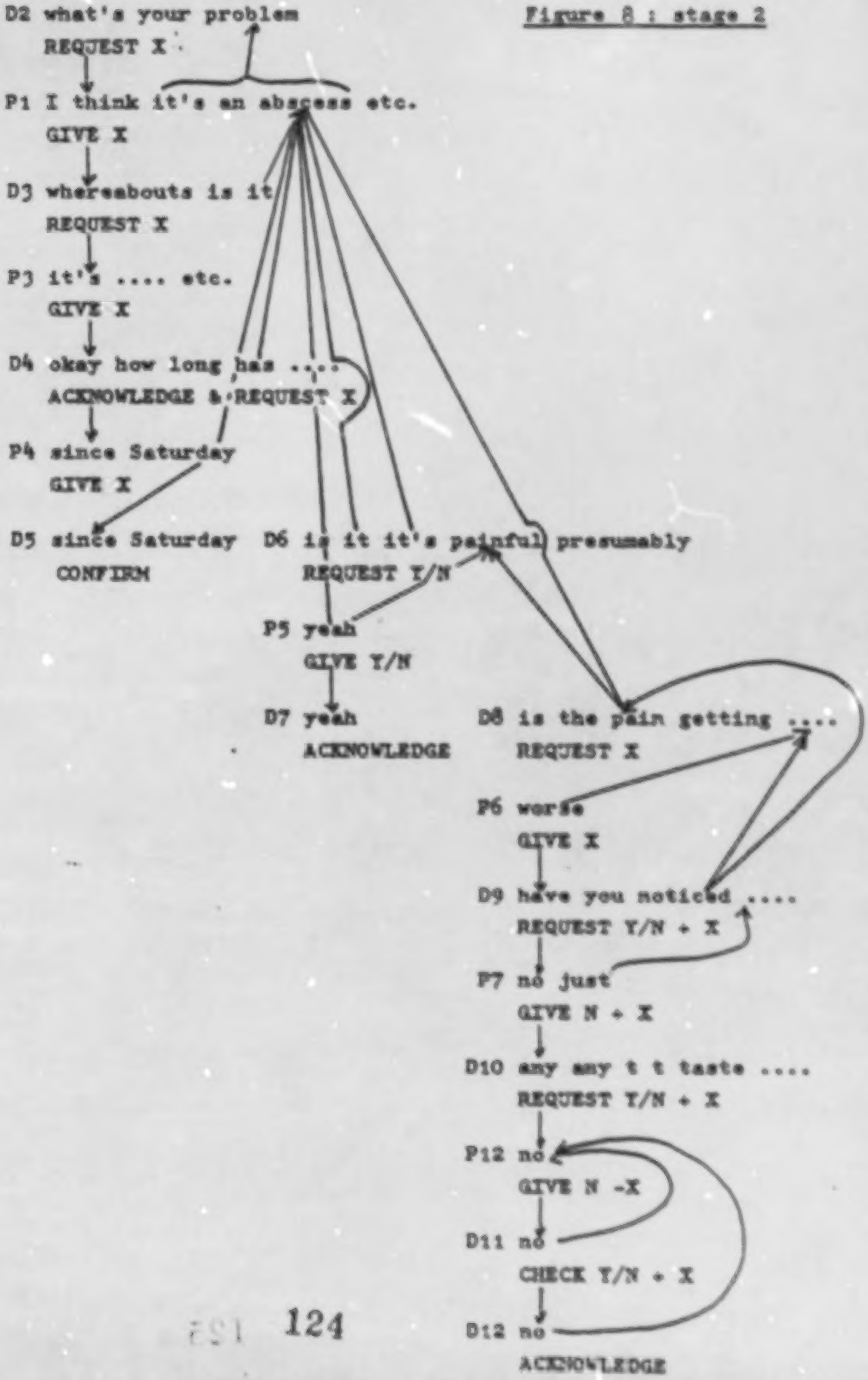
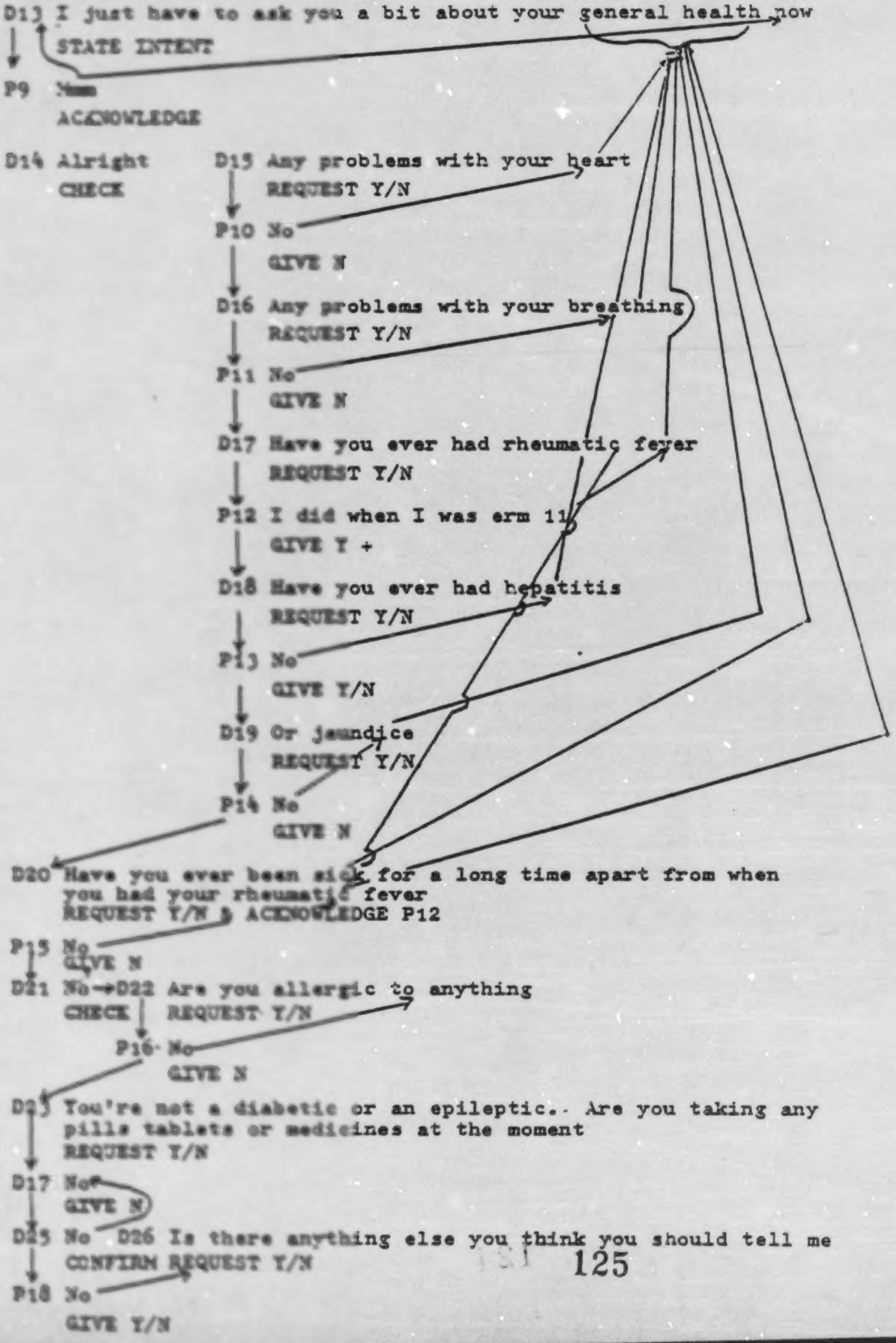


Figure 9 : stage 3



D13 I just have to ask you a bit about your general health now
STATE INTENT
P9 Mmm
ACKNOWLEDGE
D14 Alright D15 Any problems with your heart
CHECK REQUEST Y/N
P10 No
GIVE N
D16 Any problems with your breathing
REQUEST Y/N
P11 No
GIVE N
D17 Have you ever had rheumatic fever
REQUEST Y/N
P12 I did when I was erm 11
GIVE Y +
D18 Have you ever had hepatitis
REQUEST Y/N
P13 No
GIVE Y/N
D19 Or jaundice
REQUEST Y/N
P14 No
GIVE N
D20 Have you ever been sick for a long time apart from when you had your rheumatic fever
REQUEST Y/N & ACKNOWLEDGE P12
P15 No
GIVE N
D21 No →D22 Are you allergic to anything
CHECK REQUEST Y/N
P16 No
GIVE N
D23 You're not a diabetic or an epileptic. Are you taking any pills tablets or medicines at the moment
REQUEST Y/N
D17 No
GIVE N
D25 No D26 Is there anything else you think you should tell me
CONFIRM REQUEST Y/N
P18 No
GIVE Y/N

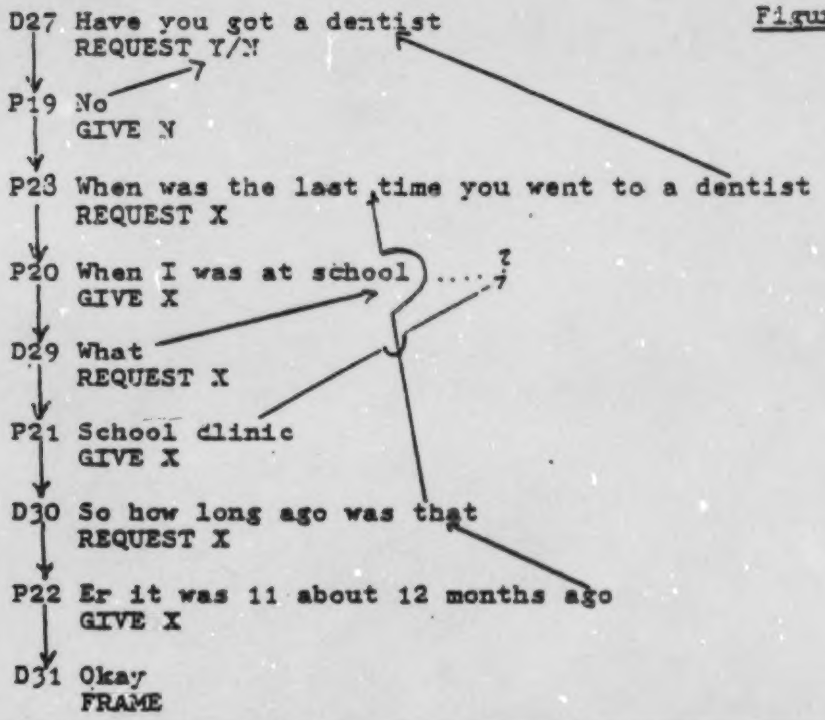


Figure 8 : stage 3 (b)

D27 Have you got a dentist
REQUEST Y/N

P19 No
GIVE N

P23 When was the last time you went to a dentist
REQUEST X

P20 When I was at school .... ?
GIVE X

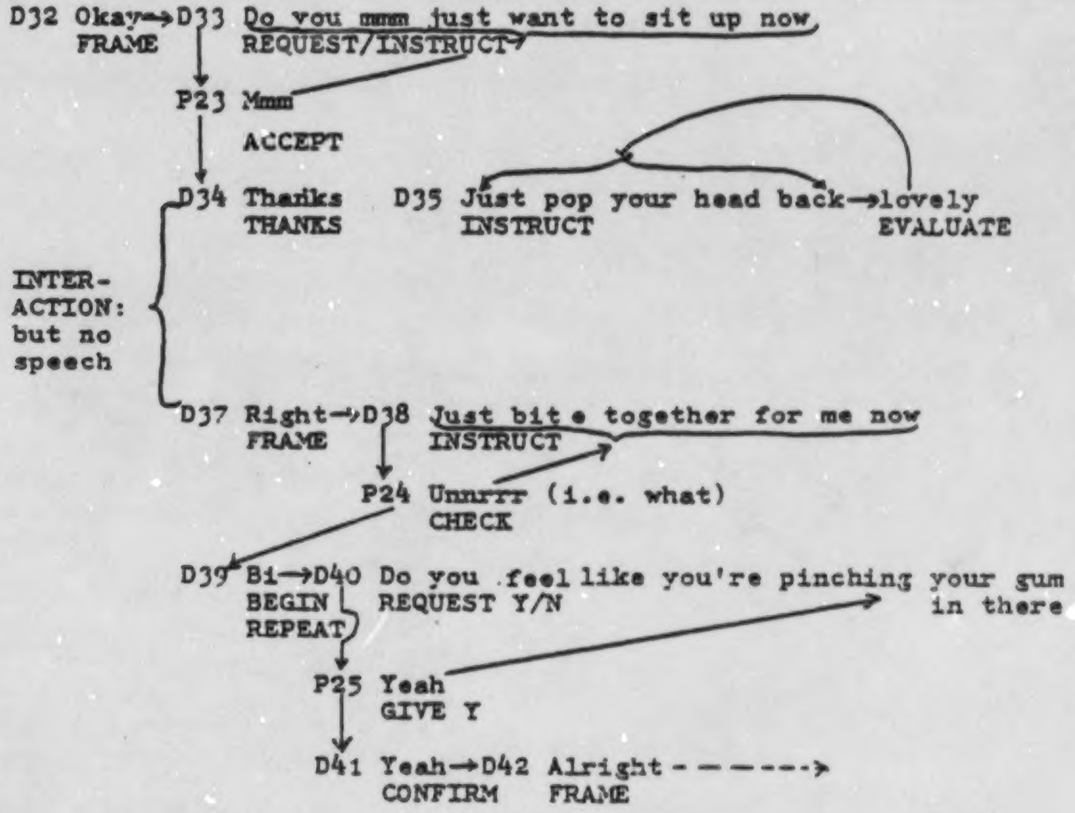
D29 What
REQUEST X

P21 School clinic
GIVE X

D30 So how long ago was that
REQUEST X

P22 Er it was 11 about 12 months ago
GIVE X

D31 Okay
FRAME



D32 Okay→D33 Do you mmm just want to sit up now
FRAME REQUEST/INSTRUCT

P23 Mmm
ACCEPT

D34 Thanks D35 Just pop your head back→lovely
THANKS INSTRUCT EVALUATE

INTER-
ACTION:
but no
speech

D37 Right→D38 Just bite together for me now
FRAME INSTRUCT

P24 Unnrrr (i.e. what)
CHECK

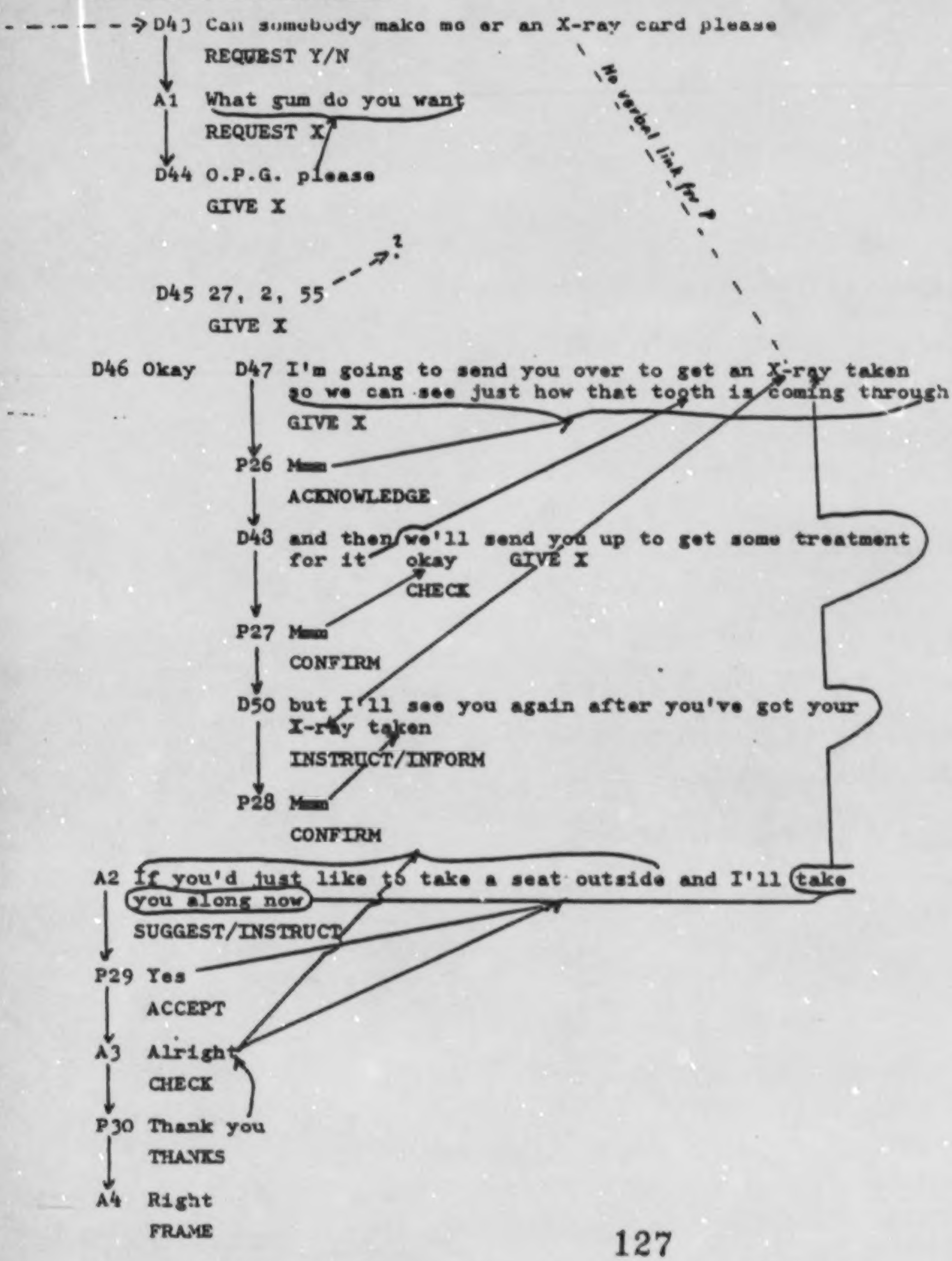
D39 Bi→D40 Do you feel like you're pinching your gum in there
BEGIN REQUEST Y/N
REPEAT

P25 Yeah
GIVE Y

D41 Yeah→D42 Alright - - - - - ->
CONFIRM FRAME

Figure 10 : stage 4

Figure 11 : final stages



D43 Can somebody make me or an X-ray card please
REQUEST Y/N

A1 What gum do you want
REQUEST X

D44 O.P.G. please
GIVE X

D45 27, 2, 55
GIVE X

D46 Okay D47 I'm going to send you over to get an X-ray taken so we can see just how that tooth is coming through
GIVE X

P26 Mmm
ACKNOWLEDGE

D48 and then we'll send you up to get some treatment for it okay GIVE X
CHECK

P27 Mmm
CONFIRM

D50 but I'll see you again after you've got your X-ray taken
INSTRUCT/INFORM

P28 Mmm
CONFIRM

A2 If you'd just like to take a seat outside and I'll take you along now
SUGGEST/INSTRUCT

P29 Yes
ACCEPT

A3 Alright
CHECK

P30 Thank you
THANKS

A4 Right
FRAME

The following pieces of 'discovered' information demonstrate the shared knowledge that must exist between speaker and listener for the conversation to take place. The patient correctly interprets it in D6 as abscess. The patient works out the correct interpretation of D29, following D28, and P21 is an appropriate answer. D13 on the surface appears to be an explanation but, in reality, it does not explain anything, it merely tells the patient what the dentist is going to do. D32 and 35 are similar. However, they have the added implicature for the patient:

sit up
pop your head back} because I am in a position to tell you to –

But the form of D32 in particular is a face-preserving move by the dentist on the patient's behalf. D43 is also a face-preserving move, on the assistant's behalf this time.

D32 and D43 are effective because they seek co-operation and not confrontation. Figures 8, 9 and 10 reveal the division of the activity and the lack of chaining links between the different stages, and the link between the stages in Figures 10 and 11 is very tenuous. Some of the verbal references are not explicable unless implicatures are made from the context, for example, D29, 39 and 45, and in D39, 45 and A1, the references are inexplicable without knowledge of the intervening non-verbal activity.

An interesting issue for future research is: does the fact that information is buried in the text have greater disadvantages for one participant rather than for another, and if the patient is disadvantaged, does this make the dentist's control of the encounter and, therefore, of the patient's behaviour in it, greater? (cf section 7 of this Report).

Transcript

Stages
1 & 2

D : hello what's the problem D1-2
[IS YOUR DENTAL PROBLEM]

P : ah I think it's an abscess on me you know me gum P1-2 (1)
[MY DENTAL PROBLEM]
at the back I think getting a wisdom tooth it's killing
me you know every time I go to chew on that side
you know

D : whereabouts is it D3
[THE ABSCESS/WISDOM TOOTH]

P : it's right at the back (you know) at the bottom P3
[THE ABSCESS/WISDOM TOOTH] [OF THE MOUTH]

SILENCE

D : okay how long has this abscess been here D4
[IN THE MOUTH]

P : since Saturday [THE ABSCESS HAS BEEN IN MY MOUTH] P4

D : since Saturday is it it's painful presumably D5-6 (2)
[THE ABSCESS/WISDOM TOOTH]

P : yeah [THE ABSCESS/WISDOM TOOTH IS PAINFUL] P5

D : yeah is the pain getting better or worse D7-8
[OF THE ABSCESS/WISDOM TOOTH]

P : worse [THE PAIN OF THE ABSCESS/WISDOM TOOTH IS GETTING] P6

D : have you noticed anything else about it D9 (3)
[THE PAIN &/OR ABSCESS/
WISDOM TOOTH]

P : no just (it's all there and up to there) pain P7
[PAIN]

D : any any t t taste at all in your mouth or anything D10
[ODD]
like that

P : no [NO ODD TASTE OR ANYTHING LIKE THAT] P8

D : no no I just have to ask you a bit about your general D11-13
now [BECAUSE THIS KNOWLEDGE IS IMPORTANT FOR TREATING Stage 3
YOUR DENTAL PROBLEM CORRECTLY] (4)

P : mmm P9

D : alright any problems with your heart D14-15
[DO YOU HAVE/HAVE YOU HAD] (5)

P : no [I DON'T/HAVEN'T HAVE/HAD ANY PROBLEMS WITH MY P10
HEART]

D : any problems with your breathing D16
[DO YOU HAVE/HAVE YOU HAD]

P : no [I DON'T/HAVEN'T HAVE/HAD ANY PROBLEMS WITH MY P11
BREATHING] .

D : have you ever had rheumatic fever D17

P : I did when (I was em eleven) P12
[HAVE RHEUMATIC FEVER]

D : have you ever had hepatitis D18

P : no [I HAVEN'T HAD HEPATITIS EVER] P13

D : or jaundice D19
[HAVE YOU EVER HAD]

P : no [I'VE NEVER HAD JAUNDICE] P14

D : have you ever been sick for a long time apart from D20
when you had your rheumatic fever

P : no [I HAVEN'T EVER BEEN SICK FOR A LONG TIME APART FROM WHEN I HAD MY RHEUMATIC FEVER] P15

D : no are you allergic to anything D21-22
[NO YOU HAVEN'T EVER BEEN SICK FOR A LONG TIME APART FROM WHEN YOU HAD YOUR RHEUMATIC FEVER]

P : no [I'M NOT ALLERGIC TO ANYTHING] P16

D : you're not a diabetic or an epileptic are you taking any pills tablets or medicines at the moment D23-24

P : no [I'M NOT A DIABETIC OR AN EPILEPTIC I'M NOT TAKING ANY PILLS TABLETS OR MEDICINES AT THE MOMENT] P17

D : no anything else you think you should tell me D25-26
[YOU'RE NOT A DIABETIC OR AN EPILEPTIC OR TAKING ANY PILLS TABLETS OR MEDICINES AT THE MOMENT]
[ABOUT YOUR MED. HISTORY]

P : no [THERE'S NOTHING ELSE I THINK I SHOULD TELL YOU ABOUT] P18

D : have you got a dentist D27 (6)
[DO YOU GO TO YOUR OWN DENTIST]

P : no [I HAVEN'T GOT A DENTIST OF MY OWN] P19

D : when was the last time you went to a dentist D28

P : when I was at school P20

D : what [WHAT DENTIST/WHAT KIND OF DENTIST DID YOU GO TO WHEN YOU WERE AT SCHOOL] D29

P : school clinic [I WENT TO A DENTIST AT THE] P21

D : so how long ago was that [WHEN YOU WENT TO A DENTIST AT THE SCHOOL CLINIC] D30

P : er it was eleven about twelve months ago [WHEN I WENT TO THE DENTIST AT THE SCHOOL CLINIC WHEN I WAS AT SCHOOL] P22

SILENCE

D : okay [THAT'S AN ADEQUATE AMOUNT OF INFORMATION] D31
okay do you mmm just want to sit up now [IN THE DENTAL CHAIR SO THAT I CAN LOOK AT YOUR TEETH] D32-33 Stage 4 (7)

P : mmm [I WILL SIT UP IN THE DENTAL CHAIR SO THAT YOU CAN LOOK AT MY TEETH] P23

D : thanks just pop your head back lovely D34-36
[THAT'S VERY HELPFUL] [SO THAT I CAN SEE MORE CLEARLY INTO YOUR MOUTH AND YOU CAN REST YOUR HEAD]

SILENCE

D : right just bite together for me now D37-38 (8

P : uunrrr P24

D : bi do you feel like you're pinching your gum in there D39-40

P : yeah [I DO FEEL LIKE I'M PINCHING MY GUM IN HERE] P25

D : yeah alright can somebody make me er an X-ray card please [FILL OUT FOR ME] D41-43 (9

A ; what gum do you want [TO BE X-RAYED] A1

D : O.P.G. please D44

SILENCE

D : twenty-seven two fifty-five oksy I'm going to send D45-47 (1C
you over to get an X-ray taken so we can just see how Stage 6
[TO THE X-RAY DEPARTMENT]
that tooth's coming through

P : mm [I UNDERSTAND AND AGREE] P26

D : and then we'll send up to get some treatment for it D48-50
[TO THE APPROPRIATE DEPARTMENT]
okay but I'll see you again after you've got your X-ray
taken

A : [IF YOU'D] just like to take a seat outside [IN THE A2 (11
WAITING-ROOM] and I'll take you along now [TO THE Stage 7
X-RAY DEPARTMENT]

P : yes P27

A : alright A3

P : thank you P28

A : right

5:2:4 CONTROL STRATEGIES IN DENTIST-PATIENT CONSULTATIONS

(Note: The attached transcript is arranged in a similar way to the transcripts in Sections 5.2.2 and 5.2.3. Attention is, however, particularly drawn to the Section D13 to D20, which receives further interpretation below in Section 6.5 of the Report)

In Stage 2 of this consultation, initiated by the patient even before she has been settled in the chair, we see the beginning of a common problem in dentist-patient interaction, namely the need to control and channel patient information and reaction (particularly in the face of patient challenge) so that it becomes progressively more relevant to the task in hand.

STAGE NO.	DESCRIPTION
1	greeting (not recorded)
2	P initiate: worry D⟶P to chair
3	check/inspect
4	prognosis (discussion between D and P about who extracted problem tooth)
5	history-taking
6	extraction
7	D⟶P suggests new dentures
8	prognosis
9	terminate

Table 18

Notice how in P1 to P12 the patient consistently uses the keep + Vbing form to describe her state of mind and condition: kept thinking, kept having, keep getting, kept hoping, particularly when linked, as they are in P3, to relevant verbs bleeding, rushing, restitching, emphasising the reasons for the patient's concern.

The dentist in D7 turns the patient's provision of information in a relevant direction for the consultation, ensuring that the dental problem and not the general health problem are dwelled on. The patient completes her account with: "and I thought (while ...) I'll er dive in to see you".

Note the patient's use of *dive* as her only use of a dynamic verb with herself (I) as subject. All other verbal phrases in preceding turns with herself as subject involve stative verbs: *I kept thinking*, *I didn't want* (2), *I*(just) *thought*, *I'll keep persevering*, *I'm* (a real bleeder),(I) (always) *have been*, *I kept having*, *I think*, *I thought*(2), *I've had* and *I keep getting*. Similarly, the only dynamic verbs she uses relate to the problem tooth: (it would) *come out*, *come out*; (the teeth) *came out*; (that) *didn't come up*, *didn't come out*, set against further stative verb phrases elsewhere in the stage: *the health hasn't been* (too good), *it's* (still there), *it's* (an old tooth), *there's* (no trouble), *it's* (quiet), *my chest's*(better) than *it's been* (for a while).

One might wish to draw from this the conclusion that despite the need for the taking of a general patient history, it is the dental condition in this case the tooth, which the patient perceives as crucial. The dentist's turns during this stage tend to mirror the patient's choice of lexis and relate to the patient's description of her condition. Of interest is D2 in which the dentist tries to direct the encounter by requesting the patient to sit down. He makes it sound as if the suggestion is due to concern for the patient by speaking reassuringly, but the underlying implicature is clearly that of a command. The patient regains the initiative in P3 by repeating P2 and continuing with what she had may well have intended to say before D2. In D3-7, the dentist gradually directs the attention of the patient to giving specific information relevant to the purpose of the consultation and by D9 the dentist is able to initiate the inspection stage. In D10 and D11 the dentist states the problem (which the patient had correctly surmised already). The dentist's intonation of D10

piece of tooth

and D11

that's come along

refers to the patient's surmise in P1 and P8 but in its implication that the information the dentist provides in D10 and 11 is more accurate and specific, also confirms the dentist's commanding role. (cf. *Brazil et al* 1980, especially on the interpersonal significance of r+ tones).

In response to D13, the patient says "four years". Note how D14 contradicts the implication of P13 that the troublesome piece of tooth is the result of this dentist's previous treatment. D4 is an overt contradiction of the convert challenge in P13. There is nothing in the language that necessitates D14, but D14 is a strong reaction to the implicit challenge offered by the patient in P13. The patient in P14 and 15 repeats the challenge, although there is nothing aggressive in her choice of language - P15 starts I think it was ... and continues it's about ... . D14 and 15 explicitly contradict the patient's contention, emphasising an almost aggressive reaction of a dentist seeking to reestablish his position of authority.

D16 acknowledges P15 but corrects it, thus once again asserting control, by implying (possibly quite rightly) that the work he did for the patient was on a different tooth. P16 acknowledges D15 but the continuation of her turn is a contradiction, although face-preserving and not overtly hostile to the dentist. The value of P16 is kept deliberately vague; it satisfies the patient's need to defend her position, without openly confronting the dentist. D17 ignores the point of P16 and repeats D14. During this episode, the dentist's utterances get progressively louder from D14 to D16 while subsiding during D17 to D19 when he perhaps realises that the patient is backing away from open confrontation. P19 is interesting because it neitherexpressesagreement with D19, nor contradicts it; it is similar to P16 in that the patient does not deny her belief, while not necessarily agreeing with the dentist.

This episode can serve as an example of one type of 'dominance' a dentist is able to exert following from his assumed rights: dentists can contradict and confront more openly than patients can. No doubt this is a calculated risk in that dentists might thereby lose patients; equally it may be called for (and permitted) by certain types of patients with particular conditions.

By D22, the dentist firmly controls the interaction, though at the cost of overwhelming the patient's reactions in D18-21. At this point he initiates a further brief medical history-taking stage, heading off any possible expansion by the patient in P24 and 25. In D27 the dentist suggests dealing with the tooth, to which the patient agrees in P28. The dentist checks this in D28 and in P29 the patient confirms and thanks the dentist thus publicly acknowledging his control of the direction of the consultation. Note how the dentist's response in D29 shows concern for the patient; there are two uses of just to soften the effect of his instructions, and examples of that's it, that's all now, alright, that's alright.

While the dentist works on extracting the piece of tooth, he speaks quietly, again serving to help the patient relax, whereas in D32 he speaks again with normal volume thus indicating that his work and the patient's problem are over. D33 and D34 confirm this.

At this point (D36) the dentist initiates another stage of the consultation by instructing the patient to lie back and open her mouth for a further inspection. The use of dear and just soften the instruct which leads into "and it's time you had some new dentures isn't it"; the implication of the rising intonation is that the patient would find it difficult to do anything but agree. D38 suggests a reinforcement of the control with the use of we (in the institutional sense), and the modal verb of intention we'll. D38 is delivered slowly and is presumably meant to be interpreted as an instruct/inform by the patient, rather than a more open-ended suggestion. P37 is an indication of the effect.

This consultation is of interest chiefly because of the strategies the dentist uses to gain and exert control over the patient and the course of interaction. The strategies appear quite overt, and the only face-preserving moves which the dentist makes are during the treatment stages when he is in control of the non-verbal activity, and consequently of any treatment-related talk. In contrast, we may say that it is the patient's strategy to maintain her own face as well as the dentist's while not necessarily agreeing with what the dentist proposes. The later stages of the consultation, however, would seem to demonstrate that the dentist fails to reciprocate the patient's face-preserving intention and reasserts his control.

5.2.4 TRANSCRIPT

P: must have something that was left in and I kept thinking it would come out come out P1

D: okay D1

P: because I didn't want a repetition P2

D: right come and sit down now D2

P: I didn't want a repetition of all that bleeding and rushing to the hospital and re-stitching so I just thought well I'll keep persevering P3

D: oh you had some [er D3
P: [oh a real old do P4
A: [excuse me
D: infection and some secondary haemorrhage on it didn't you. D4

P: yes I'm a real bleeder when the teeth came out always have been and the health hasn't been too good P5

D: no that's right D5

P: and I kept having [( ) P6
D: [and what's your trouble now D6

P: well it's still there and it er it [( ) P7
[there's something brewing there is there D7

P: yes I think its an old tooth or something that didn't come up didn't come out and I thought while there's no trouble in the mouth and I've had about I keep getting ulcers in the mouth and I thought while it's quiet and er my chest's better than it it's been for a while I'll [er P8
D: [is it yeah D8
P: dive in to see you P9
D: right let's have a look now it's still er on the same side there D9

P: mm P10
D: that's a piece of the tooth D10

P: mm P11

D: it's not a whole tooth by any means it's a piece [of a tooth D11
P: [I kept hoping it would come out P12

D that's come along D12
(THAT PIECE OF TOOTH)

P: ((chuckle))

D: I don't know when you had that out it's er D13

P: four years P13

D: no it's not one I took out for you D14
P: isn't it P14
four years
D: I've taken nothing as far back as that D15
(FOUR YEARS/POSITION IN YOUR MOUTH)

P: I think it was was it four years this October P15
coming er it's about that time since all I had
all that trouble about four years since October

D: ( ) yes but that was nearer the front that D16
(THE TROUBLE FOUR YEARS AGO)
was after you'd had teeth out down here

P: yes this has this has never I've never been to P16
anyone since I've tried to hope it would work
itself out

D: yes well that's not one I took out for you D17
(THAT TOOTH)

P: no P17

D: it's er D18

P: it's still left in P18
D: it's one that's been taken years ago D19
(THAT TOOTH)

P: is it really P19

D: yes D20

P: hm hm hm P20

P: I see hm P21
D: and a little piece has come through D21
P: it's er waltzed up P22
D: er now you're pretty well at the moment D22
are you
P: yes better than I've been for an awful while and P23
there's no ulcers in the mouth I've kept getting
ulcers in the mouth
D: yes D23

P: probably ( ) P24
D: well now er are you taking any tablets D24
or pills dear

P: er anti well I er I'm off the antibiotics at the P25
moment I'm ( )
D: you're on nothing at the moment D25

P: nothing at att my chest has been better but it's P26
just a bit of a ( ) with the cold

D: I see D26
P: the cold weather P27

D: well I think we'll get this little piece of tooth D27
out for you now shall we get it done with
P: yes P28

D: alright D28

P: yes okay thank you very much P29

D: good so just pop your head back now that't it you'll D29
just feel me pressing you that's all now alright( )
that's alright
P: oh hm hm P30

D: that's it thank you might I have a pair of lower D30
roots please that's it now

P: (thank you) P31

D: there you are D31

P: hm mm P32

D: that's it D32

P: hm mm P33

D: good have a wash out will you D33-34

P: hm mm mm P34

D: that's it no more D35

P: hm mm mm P35

D: just pop your head back dear and it's time you had D36
some new dentures isn't it

P: mm mm P36

D: lower left eight root D37

A: uh huh

D: bite together that's right well now we'll fix you D38
up with appointments for some new dentures alright
okay now then keep those dentures ind forget about
that

P: I will P37

D: I don't think that'll bleed D39

P: hm mm good P38

D: alright D40

P: that's fine Mr ________ thank you very much P30
D: good that's it D41
I just want you to sign the form now

P: yes thank you P40

D: just be careful with these wires now D42

A: will you sign this form please Mrs. (   )
((sounds of washing))

A: are you alright

D: ((cough)) those are

5.2.5 MITIGATION

We have discussed elsewhere in this Report the emphasis placed by dentists on the need to reduce the level of apprehension in their patients and to secure an environment which will promote patient retention of dentist advice.

In this sub-section, therefore, we examine briefly the phenomenon of dentist *mitigation* of the advice or instruction being conveyed to the patient: whereby the import of the message ismade more tolerable in this situation of stress.

In D10 ofthe consultationthe dentist's use of *quite* with *bad* has the effect of mitigating the negative value attaching to *bad*, taking advantage of current evaluation of *quite* as used colloquially to mean *moderately* or *fairly*. Although the dentist's use of *quite* draws attention to *bad*, it has the consequence of lessening the severity of *bad* by qualifying it.Similarly, *I'm afraid* in D11 directs the attention of the patient to the seriousness of what is coming but simultaneously mitigates it by evincing concern for the patient. This is again followed in D11 by *that's rather a bad tooth* where the intonation of *rather* emphasises the badness but the choice of *rather* (and not, for example, *very*) mitigates the badness. The phrase is ambiguous in intention: the patient can both be led to perceive the seriousness as well as satisfactorily interpreting the seriousness from his own point of view as not too serious. The fear for the patient is thus reduced. To make sure, however, that the point will be perceived, *to say the least* is added. This is a common, throwaway phrase, and because of the frequency of its use, its effect is not strong. Nevertheless it *is* used and given some emphasis, and the patient can choose how to interpret the dentist's intended emphasis. The ambiguity of the language thus enables the patient to select the interpretation that suits him and with which he feels comfortable.

The use of *pretty* with *bad* in the next move of the turn D11 is ambiguous in the same way as *quite*: it can mean *considerably* or *fairly*. The patient is able to choose the latter interpretation if he wishes. The use of *pretty* reduces the impact, whereas *very*, for example, would have had the reverse, heightening effect. The dentist, furthermore, maximises the effect of pretty (in the actual consultation) by pausing significantly before he says it.

The rest of D11 continues this pattern of assurance and face-preserving for the patient. The underlying intention appears to be to inform the patient of what else in his mouth needs attention while containing anxiety to an acceptable level and thereby ensuring patient cooperation. (Notice, too, how the patient is in effect warned about what information he is going to receive in D10 ((i.e. in advance of actual treatment)): "you've got two that are quite bad there"), the potential threat of which is then immediately reduced by the dentist treating the tooth the patient is anxious about, immediately.

D14 appears to be fairly unspecific in its request for information, but is made more important, though not threatening, by D15 and D16, which check the patient's responses. In D17, have a tooth out is used instead of have a tooth extracted, the latter phrasing being the common technical expression. This lay use is also less specific since it does not make clear whether the reference is to extraction by a dentist or not; although, clearly, most patients would probably interpret it that way. In any case the question itself is not fully understood as the patient's response P16 demonstrates.

D19 could be termed an emotive appeal because of the perjorative tone produced by it's beyond filling, quite honestly, and it's er (the pause indicates that the dentist is lost for an appropriate word) it's hopeless. Expressed like this, the move indicates the dentist's concern and is perhaps intended to imply that the other tooth needs treatment on the same grounds. The second half of D19 concerns the giving of the injection, and is broken down into short moves interspersed with action. This has the effect of breaking down the patient's apprehension of a single continuing block of pain into several smaller blocks which are easier for the patient to accommodate. The expressions used have this mitigating effect, for example, small nip that's all, just a bit cold, I'll just put a little ... . Indeed, the dentist's use of fine twice "rewards" the patient's apprehension and pain.

D33 has similar qualities in that it too deals with activity likely to prove stressful to the patient. Expressions here which indicate the dentist's concern for the patient include: *don't panic*, *alright*, and *don't worry*. The patient is rewarded by *that's right* and *good lad*. Mitigating expressions used include: *a little pressure* and *it's a rather broken down one* ('improved' by being followed by *I'm afraid*). The quiet quality of the dentist's voice in the recording contributes to the total reassuring and calming effect of D33.

The informing and instructional intent of D34 is mitigated for the patient by the emphasis of *can* with *get*, the addition of *fairly* with *easily*, and the effect of *as* in *as you can* with *keep it clean* and *try to* with *chew*. The choice of *be careful*, rather than: "you must not let food ...", further mitigates the central instructional and informing function.

D35 repeats the substance of D29 and ends with the comment:

> D: "because it's always a shame chaps in your line they always seem to lose what they might have filled *if they just had a bit more time to get organised you know*".

To the observer this introduces to mitigation an additional reprimanding value, not highlighted in our earlier comments.

TRANSCRIPT

D: o.k. D1

P: mm P1

D: alright D2

P: yep P2

D: you're having trouble are you D3

{ P: yeah the back one { I had a filling I had a filling P3
{ D: { which side D4
P: in but it all came out and it started to er(   ) P4
D: oh I see just you rest your head D5

SILENCE

D: when did it happen D6

{ P: when did it start breaking { up P5
{ D: { mm mm D7

P: well about the last couple of weeks P6
D: is it keeping you awake at night D8
P: it has the last two nights P7

D: now is it er left side bottom D9
P: mm D8

D: the very back one mm you've got two that are quite bad there this one further forwards not hurting you D10

P: no P9

D: no no pain when I touch that just open fairly wide there's no pain on that one I'm afraid that that's rather a bad tooth to say the least you've got one at the top that's pretty bad too but if your pain started on the lower and at the back well we'll remove that for you today D11

P: yeah okay P10

D: okay D12

P: yeah P11

D: you've not had rheumatic fever D13

P: no P12

{ D: d'you've any medical thing that you take tablets for { any medical condition D14
{ P: { no P13

P: no P14

D: no quite fit D15

P: yeah P15

D: apart from your tooth ache D16

P: yes P16

D: okay when did you last have a tooth out D17

P: oh about five years ago I just had a filling P17

D: oh you just had a filling D18

P: yeah I'd I think two three or four something like that P18

D: well I' ll make this numb for you and we'll get rid of D19
that one because it's beyond filling quite honestly
it's er it's hopeless just stay as wide as you can
small nip that's all fine just a bid cold I'll just
put a little in at the side to make the gum there
numb fine okay.

SILENCE

D: how long is it since you actually had a tooth out D20

P: can't remember P19

{ D: { you can't remember no D21
{ P: { ( ) well usually my teeth've P20
been alright

D: your teeth heal up pretty well so I mean you haven't D22
had excessive bleeding from an extraction you would
have remembered that if you had

P: oh no no P21

D: you heal pretty quickly D23

P: is it possible that you could clean them a bit P22

D: erm ( ) how long are you here D24

P: I'm sailing tonight P23

D: well really what you need is some of these other D25
teeth to be filled and a scale and polish your
scaling alrightyou might have a bit of stain your
stain's not that bad the urgent thing that really
needs doing the more pressing thing is filling in this
and possibly if you're lucky filling in that top one
to save it you know you need another full dental
appointment to do that

{ P: erm well { ( ) goinga Rotterdam so I don't know P24
{ D: { but if you're D26
P: whether'll be coming back at all can't really say P25

{ D: you never know when you're going to be { back n how D27
{ P: { no

{ D: long for {
{ P: { and where P26

{ D: this is the trouble you know I mean not this morning D28
I can't do this treatment for you 'cos I just don't
have the { erm available time but er if you knew when you
{ P: { time
D: were going to be here even short notice we could D29
probably do it for you do the fillings and do the
scaling

{ P: mm ( ) I'll just have to wait and see I can't { say P28
{ D: { it's a D30
bit difficult you go to Rotterdam tonight

P: mm P29

D: is your lip going numb D31

P: yeah P30

D: is your tongue numb on the left side D32

P: mm almost P31

D: alright you'll be aware of a little pressure on this D33
don't panic I'm just going to support your head just
stay quite wide open will you that's right alright
don't worry about the pressure it's rather a broken
done one I'm afraid good lad it's gone just ignore
the noises that's it have a rinse out now okay

SILENCE

A: what's that lower (left) A1

D: lower left H chart it as you'll have to be careful D34
not to let food get down in it is a lower (one) and
food can get into the lower sockets fairly easily
so keep it as clean as you can and try to chew meat
on the right side for the rest of today okay and if
P: alright P32
D: you know when you're going to be back even a couple D35
of days then when you get back give us a ring straight
away and we'll try to fix you a a treatment visit and
save some because it's always a shame chaps in your line
they always seem to lose what they might have filled
if they just had a bit more time to get organised you know
P: you know we never really P33
get time that's the trouble

D: no I'll take this off you now okay D36

P: yeah wondered what it was P34

D+A: ((laugh))
D: 'salright it's nothing to worry about D37
P: is it okay if I ring a taxi from here P35
D: yes you can ring a taxi from here yes alright D38
A: yes A2
D: thank you very much D39
P: thanks very much b bye P36
D: bye D40

5 2 6 CASUAL OR FORMAL SPEECH

(Note: This transcript is laid out as the other transcripts, with the difference that from D9 to D21 ↗ ↘ → indicate changes in pitch according to the direction of the arrows: 𝄐 is a noticeable pause and // indicate that intervening turns represent an aside. Capital letters in brackets with underlining are referred to separately in the text below).

The consultation is noteworthy because it is a mixture of casual and formal styles. This dentist takes only private patients. The surgery setting is formal and the most luxurious that was visited during the date-collecting stage, and was arranged as follows:

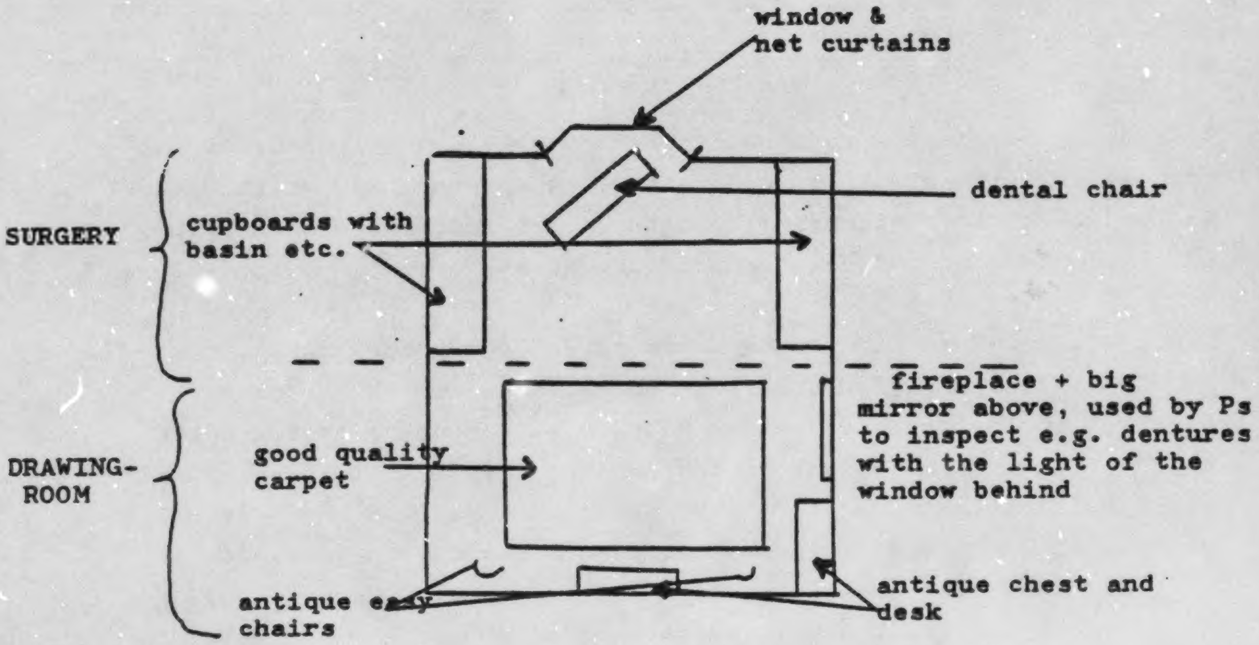


Figure 12

The patient, a female, is a regular patient who has come for a six monthly check. The dentist finds nothing wrong beyond the need for scaling and polishing, which he tends to do as a matter of course with all the patients. The consultation proceeds as set out in Table 19 below:

STAGE NO.	DESCRIPTION
1	greeting
2	inspection: read off to DSA praise P
3	prognosis
4	educate
5	manual work
6	leave-take: praise to P advice/educate to P thank you to P

Table19

In order to attempt a replication of the continuing process of communication between dentist and patient, the commentary which follows is chronological, attempting an utterance by utterance explication of the observer's understanding of the event.

The section commented upon here occurs following the inspection and is the dentist's way of offering dental education to the patient. He gives an analogy of cleaning kitchen equipment, a process with which he takes the patient to be familiar. In D9A, the dentist emphasises the point of this turn by speaking slowly and precisely, whereas in D11B, the underlined words are run together, spoken fast and the voice quality is deep and grating (cf Brown G,1977 p.141) Note too the arrows indicating pitch movement and how the downward pitch movements on feel and see emphasize those two words. In D12C the dentist speaks quickly and fluently as he extends the analogy. In D15 D marks the recommencement of the analogy at the same quick speed as D12C until he reaches the matter he wants to emphasise. At this point he pauses. He emphasises living and elides examples of exactly as [eksampləˇzækli] in casual style. Note too the pitch movements with saucepan↗ and clean↘ which seem to 'balance' the two halves of the move. A further example of elision is D16E: [səlfvləlaim], following a pause for effect. The dentist appears to use a casual, colloquial style at times in an attempt to put himself on the patient's level and establish rapport.

The intonation contour of F emphasises the similarity and contrast of the lexis and meaning: kettle is emphasised as significant because the kettle is the key to the analogy. Notice also the wavy line which means laughing tone. By injecting humour, the dentist retains the interest of the patient and communicates on a friendly level. In G there is another example of elision: and it's exactly is reduced to: [ənzækli], whereas the rest of the move it is embedded in, is pronounced carefully. Note the emphasis and pitch movement of if↗. In D19H the hesitation indicates that the dentist is thinking carefully concerning the wording of that which comes next and it leads up to the most important part of the analogy; the hesitations warns the patient that what is coming next is important.

The above analogy and its linguistic expression is important because it demonstrates how the dentist uses his voice and choice of lexis to establish personal contact with the patient. An analogy can be a 'pompous' way of illustrating a point and the dentist tries to minimise this formality in casual pronunciation and unusual variation in voice quality. At the key points of the analogy, however, he speaks clearly and precisely. This contrasts with the casual section of his talk and emphasises his points even more strongly.

An alternative way of modulating the formality of the consultation is for the dentist to use colloquial variants of technical terms, e.g. juice and sucker in D23 for saliva and salivejector respectively. But despite the patient's expression of discomfort concerning the use of the salivejector, the dentist ensures that she continues to use it in D28 with a joke: "if we don't use it you'll probably drown", and by putting it in her control. In D34, which is still concerned with the patient's use of the salivejector, the dentist's lexis is formal: "if you feel so inclined". It is not strongly emphasised, it is said quietly and quickly and it indicates that the discussion is over and that he is ready to get back to work.

In D36 and 37 the dentist's voice quality is hard to describe, but he sounds as if he is grunting or snorting out the words. The variety of voice quality that this dentist uses seems to be his main technique of becoming informal with the patient.

D39 has examples of the dentist's use of colloquial variants: lowers and uppers; he stretches out again to [əgeːɪn]; and pronounces we'll think about doing something as we'll [sɪŋk ɒbaʊt] doing [sʌmɪŋ]. Towards the end of D39, there is another example of grating voice quality.

The dentist praises the patient often; there are examples mixed in with the formal describing of the patient's teeth for the assistant in D6 and further examples in D48. Both turns also have examples of his habit of addressing the patient variously as (good) girl, love and so also does D56 where dear is used.

Colloquial and casual expression is another aspect of D48, in particular:"we'll just give them a little bit of a brush to show willing" D49 contains a further example of casual expression: shall we try and scrub 'em for you. Notice too the pronunciation in D55 of right as [rɪt] and the elision of bit and not as [bɪ^{t}ənɒt]. There is more elision in D56 with it is all pronounced as [sɔl]. Another casual expression is used in D57: "so we could let you off like that for the moment", with the frequently occurring rising intonation, implying, if Brazil et al (1979) are correct, social dominance of the speaker.

This commentary has merely isolated some examples of the dentist's mixture of formal and casual speech. Notice in particular how the use of casual expressions, elisions and colloquial variants of technical terms are meant to place the dentist on a similar footing to the patient, but how this effort is offset by the luxurious and formal setting, the dentist's formal style of working and formal phrasing and most of all, by the final rising intonation contours which have the marked effect of not allowing the patient to contradict, thus perhaps emphasising the dentist is in control and aloof. It is these strategic contrasts in linguistic and contextual features which a further study and more detailed study will need to explore.

TRANSCRIPT

D: right well you not got any teeth complaints as D1
usual I presume I hope I shall do
P: er no I haven't unless you find something that I P1
don't know about

D: but I shall do my best not to find anything for you D2
P: oh P2
that's nice
D: but er let's have a look it's too nice D3
today to mess about with teeth anyway isn't it
let's start with the top ones shall we right eight
missing seven sound as usual six has an M.O. filling
present 'salright good ( ) five there's an M.O.
four has a D.O. three two one little bit of stain still

P: mm P3

D: still smoking a little ( ) (dear dear dear) D4
P: ((laugh)) hmm P4

D: a lot D5

P: mm P5

D: oh in that case it's not a lot of stain it's only a D6
little stain and we get to the upper left five which
has a cerviacal filling present the six has er crown
full shell crown seven's okay and the eight's missing
you're doing very well excellent let's look at the
lowers then lower left eight has a D.O. filling present
little bit open again love thank you seven is sound six
has a D.O. and cerviacal filling present five's okay
four three two one one two three four has a cervi-very
sorry three has a distal present four has a cerviacal
five has a D.O. six has an M.O.D. seven cerviacal and
the eight a D.O. and cerviacal excellent very good erm
if I may have er two or three minutes I'll clean them
up a bit for you again ( ) terrible old
P: right P6
D: tobacco stain stuff but D7
P: I know ((laugh)) that's my ( ) P7

D: well there are worse things you could do I know D8
P: er I I P8
think coffee also stains my teeth

D: oh//it does yeah and to be D9(A)
absolutely accurate er if you didn't have the plaque
on the teeth it wouldn't stain at all mm if you think
about it y- when you smoke your smoke comes in from
the front of your mouth

P: yes P9

D: and yet the front of your teeth don't stain the back D10
stains

P: that's true yes ( ) front are P10
D: never thought of it did you ((laugh)) (B)
because you clean the front I'll give you a good D11 (C)
P: but I clean P11
the back as well

D: but not as thoroughly 'cause you can't feel it and you can't see it I'll give you another example of the very same thing you're living in S......... very hard water/er by the way I'm sorry to interrupt I just noticed that little bug sitting there would you mind if we put that just on the bib here or somewhere closer 'cos they can't hear the other {part of the conversation which is — D12
P: {mm — P12
D: what they're all interested in — D13

P: oh I see {yes {yeah — P13
D: ( ) heah it's a matter of communication of some sort you see and erm that's fine that'll do good erm did you switch your machine on by the way {you did yeah — D14
R: {I did/

D: erm what I was going to say is living in S . where you've got this very hard water I'll give you an example of exactly the same sort of thinking you have saucepans and they are clean — D15(D)

P: yes — P14
D: look inside your kettle 'sall full er lime same water {for both — D16(E)
P: {yes quite {yes — P15 P16
D: the only {difference is you put yourhand in the saucepan and you cleam it — D17(F)

P: yeah — P17

D: but you don't put your hand in the kettle and clean it not very often and it's exactly the same in your mouth if you could turn your teeth inside out every week or two you {could they'd look they would — D18 (G)
P: {they would (because) — P18
D: stay the same both {sides so it isn't er it isn't — D19(H)
P: {mm I see — P19
D: just the fact that it's on the inside it gets dirtier it's because {you aren't clearning and you — D20
P: {it deposits — P20
D: can't see it {that that's the big problem// — D21
P: {mm — P21

D: anyway I'll clean it up for a bit see if we can get you on the way — D22

P: alright — P22
D: {and erm this is a bit wet and splashy as usual ( ) sucker to catch the juice and here we are — D23

SILENCE

D: ( ) little bit twingy round the {edges — D24
P: {mm mm — P23

SILENCE

D: sorry want to in the way {take it out is it {getting a bit a {bit — D25-26
P: {mmhm {mm {mm — P23

D: in the way have a wash round

```
{ P:   { mm                                                        P25
{ D:   {  if you'd like to

 SILENCE

{ P:     hm it makes it hurt after a while you { know             P26
{ D:                                           { the the sucker   D27

  P:     mm
  D:     (      )

{ P:     I think so I think { it                                  P28
{ D:                        { (yes) it would do that or on the    D28-29
         other hand if we don't use it you'll{ probably drown
  P:                                         { I know              P29

{ D:   { so you can hold on the other end if you like and
{ P:   { quite yes
{ D:     and then you can ease it off { if you want to
{ P:                                  { oh I see okay              P30

{ D:     pop it in and then you can              { hold it         D30
                                  where do I hold { it             P31
{ P:
  D:     anywhere you like

  P:     I see                                                     P32
  D:     (       ) yes                                             D31

{ P:     mm (but) I must put it { in                    mm         P33
{ D:                            { you must have it in it won't     D32
         work otherwise

{ P:   { I see                                                     P34
{{D:   { (       ) down there somewhere that you can{ move it      D33
 {P:                                                { mm           P35

{ D:     around a little bit { if you { feel so inclined okay let's D34
{ P:                         { mm     { huh                         P36
  D:     do a bit more than

 SILENCE

  D:     would you like to er get rid of some of the water again   D35

{ P:   { hh                                                        P37
{ D:   { (           ) for you

  D:     hm okay well       so off again        { okay       { got that  D36(I)
  P:                ((cough))             sorry { ((laugh))  { right     P38
  D:     round that way again there we are do some from this
         side

 SILENCE

  D:     (              ) (hold it down) just a shade that's it    D38

  P:     mm                                                        P39

 SILENCE

  D:     right that does the lowers you can have a little bit of   D39
         a wash round again if you'd like to and then we'll think
         about doing something on the uppers for you
         (okay good let's try a bit round the uppers) for you

  P:                yes thank you
  D:     (I'll) have (     ) there we are put that in

  P:     now                                                       P40
```

D: ( ) pop it { in ( ) like D40
P: { y - yes you put the ( ) P41

D: that okay { ({ so let's clean the top ones I'm D41
P: { right { mm P42
D: going to need some polish ( ) in a moment D42

SILENCE

D: in the next drawer down D43

SILENCE

D: would you like to rinse that out again then just a few more to do ( ) right you doing very { well sorry if D44
P: { ((laugh)) P43
D: it's a bit sore round the edges but { ( ) most people D45
P: { that's alright P44

D: keep 'em cl{ean ( ) sucker back just another moment D46
P: { mm P45

D: other side please mm D47

SILENCE

D: good girl well done ( ) rinse that out again if you'd like to and we'll just give them a little bit of a brushing to show willing and then you'll have a better chance of keeping (it) right on top of it but you you're gonna have teeth for a long time yet nevertheless D48

P: (laugh) P46

D: okay shall we try and scrub 'em for you D49

SILENCE

D: d'you want to rinse that much out again ( ) D50

P: { ((cough)) { ((cough)) sorry ((cough cough)) P47
D: { have a polish at this si{de mm D51

SILENCE

D: not too wide again not too wide that's right D52

SILENCE

D: alright you can wash that away let's go round the top ones D53

P: ((cough))

D: ( )

SILENCE

D: and rinse away once more and we'll just do the outside edges D54

P: ((cough))

D: right last little bit n' not too wide now fine D55

SILENCE

D: there we are dear { 'sal done very good D56
P { mm lovely P48
D: so we could let you off like that for the moment D57

P: yes P49

D: and just have your bib off D58
P: with clean teeth again P50

D: so yes nice and clean and all in good order and now D59
you know what you're gonna have to do with 'em turn
'em inside out every couple of weeks and see if you
P: oh hes yes P51
D: can do the insides okay fine well done D60
P: ((laugh)) P52
P: thank you P53

D: so we'll let you off like that all being well for D61
P: so I'll P54
D: another few months

P: that's right P55

D: thank you for your help D62

P: ( ) P56

D: well you brought the teeth we couldn't've done D63
without you

P: I just (tried not to) shout P57
D: ( )

D: you didn't speak too much that's a good point D64

P: thank you very much bye bye P58
D: thanks very much D65

D: and see you all being well in about six months D66

P: yes thank you very much P59

6 : THE PATIENT'S SELF-DIAGNOSIS AND THE DENTIST'S RESPONSE

6 : 1 INTRODUCTION

The process by which the patient communicates his reasons for attending for consultation and by which the dentist reacts to the patient's report (inclusing the announcement - if any - of his own diagnosis) has been selected as a subject for particular analysis. The crucial importance of the extraction of information from patients has been emphasised by Shuy (1973):

> Recent research in the communication between doctor and patient has revealed shocking evidence of what happens when a field ignores function at the expense of technology. Although 95 per cent of the potential success of medical treatment depends on obtaining accurate information from the medical history interview, little or no attention is given in medical schools to the training of physicians in interviewing techniques or the language and culture of patients from different socioeconomic, racial, or ethnic backgrounds.
>
> (p 325)

Whilst this comment refers specifically to the importance of accurate information to medical treatment, it may be assumed that, for dental treatment, the availability of accurate information is no less important.

Nevertheless, dentists participating in the project frequently claimed that, in the majority of cases, diagnosis of patients' complaints could be made by simple visual examination. Only exceptionally did dentists feel that they had to supplement a visual examination with interrogation. These dentists suggested, therefore, that the questions they asked a patient about his condition were 'ceremonial' rather than functional. The unstated corollary to this is that the information supplied by the patient can in most cases be ignored.

It is impossible for an observer who is naive of dental science to make an objective assessment of the validity of this argument. However, it is possible to gauge how widespread this belief is among dentists: this will become apparent from the results of the dentist attitude survey referred to earlier (and cf Appendix 2). It is also possible to discover the extent to which patients feel the need to describe their symptoms to their dentists. This will become clearer when the results of the patient attitude survey referred to above are available (and cf Appendix 3). At the least, it may for the time being be assumed that patients have expectations that they will be asked to describe their symptoms, or that they feel the need to describe their symptoms. Frustration at this point may influence the further development of the consultation. Fitton and Acheson (1979), in their study of doctor-patient relationships in two general practices in the Manchester area, found:

> Failing to meet patients' expectations can be a further barrier to effective interaction. For some patients satisfaction with a consultation will be a reflection of the extent to which their expectations have been fulfilled. . . . . . Thwarted expectations did on occasion lead to dissatisfaction but by no means always. As would be expected, the degree of dissatisfaction appeared to be in direct correlation with the strength of the expectation.
>
> (p. 85)

It is argued, therefore, that patients bring with them to the dental consultation the expectation that the examination will be supplemented with questioning. The fulfilment or disappointment of these expectations may colour how the remainder of the consultation progresses.

A third reason for considering the process of information giving and information-extracting is that the techniques employed by the dentist during this stage may be indicative of the dentist's general style or approach. Thus Byrne and Long (1976), in their analysis of the verbal behaviour of general practitioners and their patients, found that this stage of the consultation is "very much related to the style of the doctor" (op. cit. p. 37).

Thus:

> The problem with attempting to categorise the things patients say is made confusing by virtue of the fact that verbal ranges are so different, as is an understanding of sickness. The doctor, on the other hand, is much more consistent. . . . . . The way in which questions are asked by doctors is remarkably consistent. (p. 39)

Byrne and Long identify four major consulting styles. These are characterised as 1). 'Gathering Information', 2). 'Analysing and Probing', 3). 'Clarifying and Interpreting' and 4). 'Silence, Listening and Reflecting'. These styles are equidistant along a continuum which ranges from total dependence on the doctor's special skills and knowledge at one extreme (in which case the doctor simply gathers information) to total dependence on the patient's knowledge and experience at the other extreme (in which case the doctor listens and reflects).

The general area of patient's communication of complaint and dentist's response is the focus of this section of the report. The three major reasons for this selection are, firstly, that accurate information is important from a medical point of view; secondly, that dentists and patients apparently have contradictory perceptions of the role which the patient's description of his symptoms should play; and, thirdly, that the techniques employed by the dentist during this stage may be indicative of a general style.

6 : 2 CONTEXTS AND CATEGORIES OF CONSULTATION

The data available for this study have been summarised in section 2 above. The data were collected in three different contexts. These were:

(a) Consultations in a general dental practice.

(b) Consultations in a hospital examinations department.

(c) Consultations in dental hospital treatment departments.

Four major categories of dentist-patient consultation have been identified. These are:

(a). Patient-initiated.

(b). Third-party-initiated.

(c). Dentist-initiated (check-up).

(d). Dentist-initiated (continuing treatment).

Patient-initiated consultations occur when a patient seeks treatment or advice either from a dentist who has already treated him at some time previously or from a new dentist. Generally speaking, the patient is suffering from a complaint which he believes the dentist will be able to help him with. In patient-initiated consultations the dentist has no indication, before examination commences, as to why the patient has come. The patient alone is aware of why the consultation needs to take place.

Third-party-initiated consultations typically occur when the patient has been referred from his general practitioner or from his own dentist to a dental hospital. In this situation, the patient and dentist are almost certainly unknown to each other and the dentist has never previously examined the patient. Nevertheless, he will have read (or will commence the consultation by reading) a referral note which will provide at least some indication of the patient's complaint. When compared with patient-initiated consultations, therefore, third-party-initiated consultations suggest that the pendulum of 'control of data' has swung somewhat in the direction of the dentist.

Dentist-initiated (check-up) consultations typically take place every six months (more frequently in some cases, particularly with hospital patients). In these cases, the dentist and patient are already acquainted with each other and the dentist will have a detailed record of the patient's dental history. The patient may or may not bring with him a new complaint, and the dentist may or may not discover new symptoms which require treatment.

Finally, dentist-initiated (continuing treatment) consultations involve patients who are undergoing a course of treatment which cannot be completed in one consultation. Typically, the patient returns once a week for a further stage of treatment. In these cases, the pendulum of control of data has swung completely in the direction of the dentist. The dentist knows precisely what treatment is to be given to the patient, where as the patient himself may have only a sketchy idea of what is being done to him. Very frequently the patient experiences none of the urgency which inspires him to initiate a type (a) consultation. That is to say, he is probably experiencing no pain or discomfort: he attends for treatment because he has an appointment, not because he seeks relief of pain.

The frequency with which each of the four type of consultation occurs varies significantly from context to context. In the available data, only two of the thirty consultations in general practice were patient-initiated, and none were third-party-initiated. Five consultations were of type (c) (dentist-initiated check-ups), whilst the majority were cases of dentist-initiated continuing treatments. In the hospital examinations department the vast majority of consultations were patient-initiated (18 of 21 cases), two were dentist-initiated (continuing treatment) consultations in which the patients were recalled from the waiting room to be told the results of X-ray examinations, and one was a case of third-party initiation. In hospital treatment departments the situation differed again. Here, dentist-initiated (continuing treatment) consultations and third-party-initiated consultations were equally frequent (six cases each, from a total of fifteen); there were two cases of dentist-initiated (check-up) consultations and one of a patient-initiated consultation. These figures are summarised in Table : A chi-squared test applied to the table suggests that there is very strong evidence of an association between the type of consultation and the context in which the consultation takes place.

TABLE : DISTRIBUTION OF 66 DENTIST-PATIENT CONSULTATIONS BY CATEGORY AND CONTEXT

		CONTEXT OF CONSULTATION			
		General Practice	Hospital Examinations Department	Hospital Treatment Departments	Totals
CATEGORY OF CONSULTATION	(a) Patient Initiated	2	18	1	21
	(b) Third-Party Initiated	0	1	6	7
	(c) Dentist-Initiated (check-up)	5	0	2	7
	(d) Dentist-Initiated (continuing treatment)	23	2	6	31
	Totals	30	21	15	66

6 : 3 DENTIST-INITIATED (CONTINUING TREATMENT) CONSULTATIONS IN THE CONTEXT OF GENERAL PRACTICE

It was suggested above that the patient participating in a type (d) consultation generally experiences little of the urgency which may on another occasion lead him to take the initiative in seeking treatment. For the dentist himself, the task which is to be performed during the consultation is so self-evident that, when the patient enters, there may be little or no review of the patient's condition. Indeed in several consultations treatment commences as soon as the patient sits down, as Extract (1) illustrates.

(1)

((P enters and sits down))

((D and R discuss position of microphone for audio-recording))

((D washes hands))

D : right, right can I have the bite blocks please

DSA: (   ) sorry

D: have you got the bite blocks   bite blocks   thankyou
right now just pop your head back will you   you've got
your teeth in have you

P : yes

D : close together on your   on your back teeth   you're
quite relaxed now   right together close right together
that's it ((etc.))

Consultation 4:1

Other dentists were observed to confirm with the patient what treatment was to be administered before they began work, as in

Extract (2).

(2)

((P enters and sits down))

((D and R discuss position of microphone for audio-recording))

D : thank you eh are we doing everything today Sue is it
erm fillings and
P : I think it's

D : er and a tooth to come out yeah right
P : two fillings and yeah

((Pause))

D : have you ever had a tooth out with a local before

P : yeah

((etc.))

Consultation 12:1

Clearly when a consultation opens in either of the manners illustrated above the patient is presented with no overt opportunity to discuss any new symptoms or any other problem which he may be experiencing. The patient must wait until the dentist himself discovers a new symptom, wait until the dentist makes a specific enquiry, or select a suitable opportunity during the consultation to introduce the matter which requires attention. In many consultations of this type, in fact, the patient plays a passive role and is never invited to comment on the present state of his dental health. It is impossible to judge whether or not any of these patients would have discussed new or continuing symptoms had they been given the opportunity to do so. However, it is significant that Fitton and Acheson (1979) found that not infrequently doctors' patients in general practice failed to discuss with their doctors the problem which was most concerning them, because, at the last minute, embarrassment, fear of the truth, awe of the doctor or some other factor inhibited them.

There were only two instances among the 'continuing treatment' consultations in general practice in which a patient-initiated discussion of a new symptom occurred. An extract from the first of these follows. This episode occurred approximately five minutes after the consultation commenced.

(3)

P : wh- can I see there is it is it going a fair way

D : there's a little discolouration (where) that would be but
that's coming from a way back before you lost the tooth

P : oh is [it oh that's alright
D : [that's usually natural don't worry on that score
there Chris

P : every time I clean it I think my god that's [going the same way
D : [that's going as well yes

D : now let me just do something for you here there's a permanent type filling but it's only as far as I'm concerned a temporary solution to the thing ((etc.))

Consultation 12:5

This patient is a particularly talkative person and takes a lively interest in the treatment which she receives. On several occasions during the consultation, for example, she reminds the dentist of treatment he has promised to provide her. To that extent patient 12 : 5 is exceptional.

The following is extracted from the only other 'continuing treatment' consultation in which a patient-initiated discussion of a new symptom occurs.

(4)

[P : you're not going to swear it's going to all go [very well
[D : [it's all going
[to be

D : right is it I see well I I I admire your optimism if not your

D : accuracy let's find out what happens [er
P : [( ) eaten one of the
crowns

D : I hope you enjoyed it

P : I had it for my lunch on Wednesday it's gone

D : well have you any toothache from it have you

[P : no [I haven't so [I've done very well
[D : [no [(I) ( ) you did do well

DSA: (d'you want this pin)

D : yes we we'll have that out of the way we have erm three
crowns ther which hopefully we shall stick in for you and we
have a wax based er that's the three on the side closed together.

Consultation 22:3

In this case the dentist does respond to the patient's report of a new symptom with "well have you any toothache from it have you", but in both consultations 12:5 and 22:3 the dentist indicates little willingness to be diverted from his predetermined treatment programme.

We have looked at consultations in which the patient is not invited to comment on the present state of his dental health. This occurs in nine of the twenty-three consultations which can be classified in this group. There are, however, other consultations in wnich the patient is proveded with an overt opportunity to report new symptoms or problems associated with the most recent stage of treatment. An example is given in Extract (5).

(5)

((P enters and sits down))

[D ((to DSA)): er oh Mrs [Hives Jeanette
[P : [morning (another good day)

DSA: yes how are you alright

D : hello

((D, P and R discuss audio-recording equipment))

D : how's that filling huh

P : oh it's alright [it's not caused any trouble [anyway might ( )
[alright [right over you go

D : right ((pause)) right where was it top right

P : mm

D : okay just trim that up and clean your teeth up

(consultation 4:3)

The patient is constrained to make her reply relevant to the treatment which she received during her last consultation. She is still not given total freedom to discuss wider aspects of her dental health.

In the following consultation, the patient is similarly constrained by the dentist's question to restrict his answer to one specific area. However, the patient attempts to use this as a cue to introduce a problem which he is experiencing.

(6)

D : now we're going to take impressions for you today okay

P : yeah

D : we'll take these out and these thank you how old were these dentures
P : yeah 'kyou

D : ( ) fifteen
P : oh ( ) 'bout fifteen year I think I think they must be at least

P : fifteen probably more

D : 'n you've not a lot of ridge down there have you

P : nothing

D : you don't have any pain under the lower dentures though

P : not as a rule but I have just a little bit here at
D : when they move about ( ) you can you can yeah

P : the moment

D : Yeah but generally speaking when you had your denture
fitted initially

D : it was fairly comfortable
P : these ones never troubled me at all

D : no no

P : they they're only trouble since I put these new ones in and
it seems to ruin this gum here (it always does it) ( ) I
brought them

D : you brought them with you

P : ( ) (here) ( )

D : well it's alright I don't need to see them at the next
appointment that's

D : the important time okay right
P : mm

Consultation 7:5

The patient tries twice to bring the problem of gum pain co the dentist's attention. On both occasions, however, the dentist is apparently unwilling to allow his examination to be diverted from the specific aim which he has already established for it.

In the extract which follows, the dentist employs a very similar type of specific questioning, and the patient responds with a very similar attempt to extend the scope of the discussion. She does this by answering with a curt "yeah" and then immediately asks the dentist a question which allows her to introduce her problem.

(7)

D : good ( ) and these fillings have settled down up there
have they

• P : yeah you know where that tooth came out

D : mm

• P : I've got a lump on the side now a little hard {lump
D : {does it hurt

P : no

D : let me just see

P : not yet

D : no well there there won't what you're feeling is the that's perfectly normal you're feeling the edge of the bony socket it sometimes doesn't heal in a completely rounded er shape it wometimes has a s-spikiness here or there which takes a little while to round off that will round off and disappear don't worry have you got the chart

DSA: mm

D : see what's still to do

Consultation 7:7

The patient's technique is successful and the dentist pays detailed attention to her complaint.

Very occasionally the patient is asked a general question allowing him to introduce a new problem to which the dentist then pays attention. The following extract illustrates this.

(8)

• D : come and sit down er right how's your tooth been or er any problems

P : no this one's been fine

D : when you say this one like that

P : (   ) root came out (   ) bit rough but er it's er if (   )
D :   oh

P : last couple of days (   ) (but) I've not when the tooth came
D : .   erm

P : but the   at the side where the injection went

D : the injection made it sore

P : mm

D : but you say a piece a piece of tooth came out

P : (no no no it's just been sore as well)

D : sore from where I extracted the root
P : ( )   no at the side in the gum

D : yeah   it looks a bit sore just down there

P : (   ) (   ). (   )

D : oh dear dear dear that does look sore too doesn't it

Consultation 22:4

The particular interest of this consultation lies in the form of the dentist's question, which begins specifically, similar to those we have observed in earlier extracts, but which then becomes more general ("How's your tooth been or er any problems"). This is especially unusual.

We have been arguing in this section that in dentist-initiated consultations in general practice in which a course of treatment advances one stage further the patient is most likely to experience either:

(a). No invitation to discuss new or continuing symptoms whatsoever; or

(b). An invitation to discuss only that treatment which he received at the most recent consultation.

The patient who wishes to bring a new problem to the attention of his dentist must employ one of the following techniques:

(a). If he receives no invitation to report new symptoms, he must initiate discussion of them at a suitable opportunity;
or

(b). If he receives an invitation to discuss earlier treatment, he must respond to that invitation in as concise a way as possible, and then promptly describe the new symptoms which are disturbing him.

In both cases, the patient's description of his new symptoms is likely to be brief and precise, since he has little opportunity to be expansive. (The significance of this comment will become apparent later).

Of course these observations do not in any way suggest that the dentist's professional skill and judgment are in doubt. This analysis is concerned with the techniques which the patient and dentist employ in their negotiations with each other and in the performance of their respective roles.

6 : 4 DENTIST-INITIATED (CONTINUING TREATMENT) CONSULTATIONS IN THE CONTEXT OF HOSPITAL TREATMENT DEPARTMENTS

The concentration of attention in the previous section on continuing treatment consultations in the context of general practice is not intended to indicate that similar types of treatment in the context of a hospital treatment department possess significantly different characteristics. In fact the observations made in the previous section also apply very largely to consultations in hospital treatment departments. There are, for example, consultations in which the patient is not invited to make any report about the state of his or her dental health and is therefore obliged to seize an opportunity to discuss the problem. This is illustrated in Extract (9).

(9)

P : I went to see (   ) and she looks really (   ) fantastic I
said oh ((laughs)) when my turn comes round she did she looked

P : really actually gorgeous a mop of dark hair just like Sean
D : she's got a

D : ahh

P : this is very loose again

D : is it

P : it's it because (when I) (   ) all along there
D : mm

D : is one of the bands loose

P : mm and the elastics what you give me last time somewhere
D : yes

P : between here and home I've lost them but
D : on on between here and

P : yeah after I left I was
D : home or between home and here which way were you going

P : going home well I di-
D : and you didn't tell me I could have sent

D : some in the post ((etc.))

Consultation 21:3

Patients are not given any specific opportunity to discuss new or continuing symptoms in three of the six dentist-initiated (continuing treatment) consultations which occur in hospital treatment departments. One of these three patients seizes an opportunity to discuss her problem, as Extract (9) above illustrates, but the other two make no effort to initiate discussion of their treatment.

In the remaining three of the six dentist-initiated (continuing treatment) consultations, the patient is asked a specific question relating to previous treatment. This, however, may or may not be exploited by the patient as an opportunity to begin discussion of a new problem. The following example is ambiguous. The patient seems to wish to relate the symptom "it's hitting the nerve (like)" to the dentist's injunction not to "relax up there". At first the dentist appears reluctant to consider the patient's excuses for lack of diligence in cleaning his teeth ("yeah I know") but then at last reacts to the patient's complaint by asking "is it still the same".

(10)

D : yes well you can't afford to relax up there can you
you see I mean you
P : no I mean uh

D : keep the plate in all the time yeah I know
P : that's right ( ) I mean (as if) it's hitting the nerve
(like)

D : yeah I know is it still the same

D : much the same innit it's a bit better
P : uh think it's probably it is a bit a bit better than it was

D : but it's still there still decay there can you get a cons thing
I just want to put some zinc oxide (eugenol) dressings in there
((etc.))

Consultation 26:1

In the last two consultations in this category, specific questions from dentist to patient are answered specifically and are not exploited any further by the patient.

6:5 PATIENT-INITIATED CONSULTATIONS

In the available data, patient-initiated consultations occur only twice in the context of a general practice, and once in a hospital treatment department (which to some extent resembles a general practice). The majority of patient-initiated consultations - eighteen cases - were observed in a hospital examinations department. The characteristics of the process by which the patient describes his problem and the dentist reaches his diagnosis will be described in each of the three general practice or treatment department cases.

The following extract is taken from a consultation in which a merchant seaman attends for treatment at the practice of a dentist whom he has never met before and whom he will almost certainly never meet again. The dentist open the consultation with a question which reveals the patient's first and major problem.

(11)

D : okay

P : (mm)

D : alright

P : yep

D : you're having trouble are you

[P : yeah the back one [I had a filling I had a filling in but it came out
[D : [which side

P : out and it started to er (   )

D : oh I see   just you rest your head when did it happen

{P : when did it start breaking {up
{D :   {mm mm

P : well 'bout the last couple of weeks

D : is it keeping you awake at night

P : it has the last two nights

D : is it left side bottom

P : mm

D : the very back one mm you've got two that are quite bad there

{D : this one further forwards not hurting you no no pain when I
{P :   no

D : touch that   just open fairly wide   there's pain on that one   I'm afraid that that's rather a bad tooth to say the least you've got one at the top that's pretty dad too but if your pain started on the lower and at the back well we'll remove that for you today

P : yeah okay

Consultation 7:3

Later in the consultation, the patient initiates a second, different request.

This comes immediately after the local anaesthetic has been administered.

(12)

P : is it possible that you could also clean them a bit

D : erm (   ) how long are you here

P : er I'M sailing tonight

D : well really what you need is some of these other teeth to be filled and a scale and polish your scaling alright you might have a vit of stain your stain's not that bad the urgent thing that really needs doing the more pressing thing is filling in this and possibly if you're lucky filling in that top one to save it you know you need another full dental appointment to do that

[P : erm well [(   ) goinga Rotterdam so I don't know whether'll
[D :   [but if you're

P : be coming back at all can't really say

[D : you never know when you're going to be [back 'n how long
[P :   [no

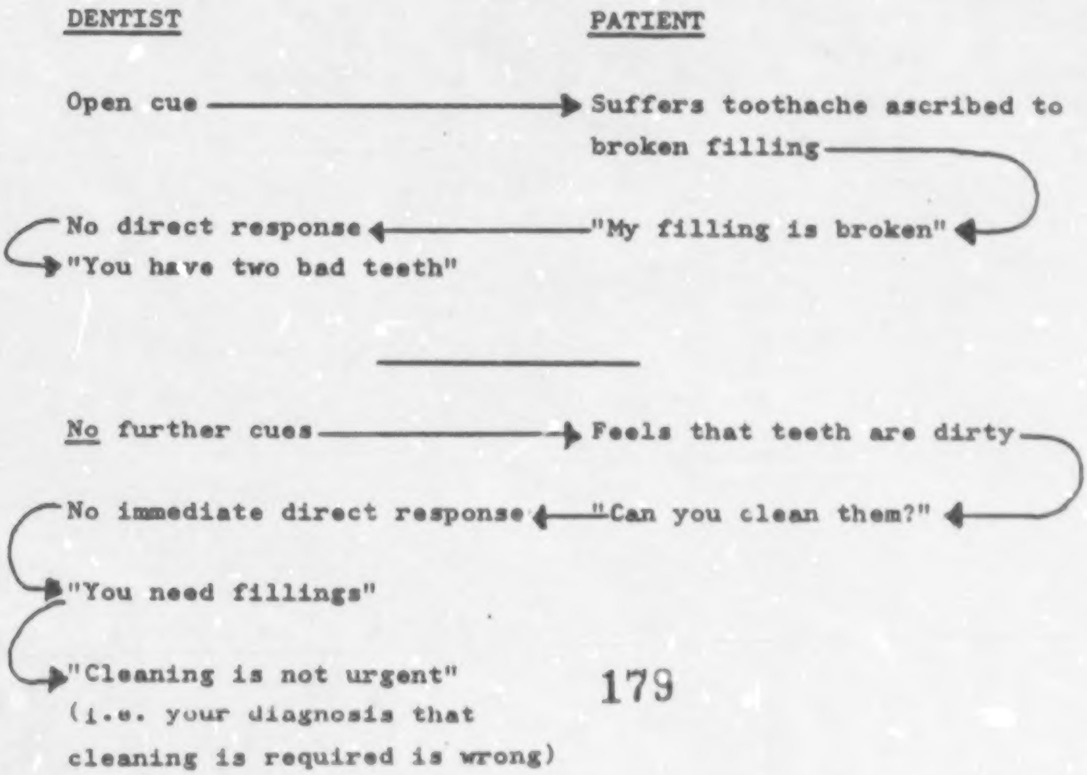
D : for   this is the trouble you know I mean not this
P :   and where

[D : morning I can't do this treatment for you 'cause I just don't have the [erm available time but er if you knew when
[P :   [time

D : you were going to be here even short notice we could probably do it for you do the fillings and do the scaling

Consultation 7:3

The patient, then, perceives that two matters require attention. The first is that a filling has started to break up, and the second is that his teeth need cleaning. In the first case the patient describes, briefly, an event which took place in the recent past (the break up of his filling) and which he believes is the cause of the problem which he is presently experiencing (pain), although pain itself is not mentioned by the patient. The dentist responds to the patient's analysis of the situation not by referring to the broken filling but by the statements "mm you've got two that are quite bad there" and "I'am afraid that that's rather a bad tooth to say the least". In the second case the patient asks the dentist if it would be possible to have his teeth cleaned, presumably indicating that in the opinion of the patient his teeth are in need of cleaning. Again, the dentist responds to the patient's analysis of the situation by introducing a completely new element ("what you need is some of these other teeth to be filled") and only then referring to the request for cleaning; the dentist clearly believes cleaning to be of minor importance in comparison with the patient's other problems ("your scaling alright you might have a bit of stain your stain's not that bad"). The process of patient complaint and dentist response, then, can be summarised as follows:


DENTIST
PATIENT
Open cue
Suffers toothache ascribed to broken filling
No direct response
"My filling is broken"
"You have two bad teeth"
No further cues
Feels that teeth are dirty
No immediate direct response
"Can you clean them?"
"You need fillings"
"Cleaning is not urgent" (i.e. your diagnosis that cleaning is required is wrong)

That is to say, the patient describes both his symptoms indirectly, and the dentist responds to both reports indirectly. Although the patient is eventually told that cleaning is not urgently required, he is never informed whether or not his analysis of thle first problem (broken filling) is accurate.

The second patient-initiated consultation in general practice involves a middle-aged lady and the dentist who has treated her for some years. The patient is attending with a completely new symptom. She enters the surgery talking.

(13)

P : must have something that was left in and I kept thinking
it would come out come out

D : okay

P : because I didn't want a repetition

D : right come and sit down now

P : I didn't want a repetition of all that bleeding and rushing to the hospital and restitching and so I just thought
well I'll keep persevering

D : oh you had some er infection and some secondary haemorrhage
P : oh a real old do
DSA: excuse me

D : on it didn't you

P : yes I'm a real bleeder when the teeth came out always have
been

P : and the health hasn't been too good and I kept
D : no that's right

P : having ( )
D : and what's your trouble now

P : well it's still there and it er it (   )
D :   there's something

D : brewing there is there

• P : yes I think it's an old tooth or something that didn't come up didn't come out and I thought while there's no trouble in the mouth and I've had about   I keep getting ulcers in the mouth and I thought while it's quiet and er my chest's better than it's been for a while

P : I'll er   dive in to see you
D :   is it yeah

D : right let's have a look now   it's still er on the same side there

P : mm

((pause))

• D : that's a piece of a tooth

P : mm

• D : it's not a whole tooth by any means it's a piece of a tooth
P :   I kept hoping it

D :   that's come along (when nobody could see it)
P : would come out

P : ((laughs))

Consultation 4:13

This consultation contrasts interestingly with consultation 7:3 which was discussed earlier. Firstly, the patient does not wait until the dentist provides her with an invitation to report her complaint before she begins speaking. Secondly, the patient is extremely talkative. Thirdly, the patient's attention is focussed primarily on her own reactions to and thoughts about the problem and the potential consequences of the problem ("I kept thinking it would come out", "I didn't want a repetition of all that . . . . ", "and I thought while there's no trouble in the mouth", "and I thought while it's quiet" and "I kept hoping it would come out"). Thus, this patient differs from the patient of consultation 7:3 in her talkativeness and in the precise focus of her attention. But the two patients are similar in that they report their problems indirectly: One through a description of recent events which have taken place in his mouth, the other through a description of affective reactions to the problem. The latter patient, indeed, is indirect that the dentist is obliged to ask two specific questions ("and what's your trouble now" and "there's something brewing there is there"). To the second of these questions the patient responds with her own diagnosis: "it's an old tooth or something that didn't come up didn't come out". This diagnosis is very similar to that of the first patient ("I had a filling in but it all came out") when describing a recent event. The sudden appearance of a non-erupted tooth is assumed to be the cause of the pain, but the pain itself is not mentioned.

This consultation differs from Consultation 7:3 in that the dentist, almost uniquely, refers to the patient's own diagnosis when he presents his own. Thus the dentist himself concludes "that's a piece of a tooth" which then allows him to contradict the pstient's diagnosis: "it's not a whole tooth by any means".

This consultation may be summarised as follows:

DENTIST	PATIENT
	suffers toothache ascribed to newly erupted tooth which may lead to excessive bleeding"
no direct response ←	"I am worried about bleeding"
"what exactly is the problem"? →	"a new tooth is erupting"
"a piece of a tooth is erupting; your diagnosis is wrong" ←	

The similarities between the two consultations which are revealed by this analysis should be clear. In brief, the patients (whether prompted or not) report their problems in ways which are more or less indirect, and the dentists' eventual responses either make no reference to or contradict the patients' own diagnoses.

The one consultation of this type (patient-initiated) which occurs in a hospital treatment dpeartment is somewhat more complicated than either of the two which occur in general practice, although to some extent the complication is a function of the duration of the consultation (a few seconds under half an hour, compared with Consultation 7:3's 6 minutes 15 seconds and the 4 minutes 55 seconds of Consultation 4:13). The patient is not attending the hospital for the first time, although she has never previously met the dentist who is to examine her.

(14)

D : now you're no stranger to this place though are you   been
P : eh what's
    em

D : been going on   can you bear to tell me about it
P :   ((gasps))   well every time they're

D :   yeah well what's the actual
P : cleaned off it seems a lot better   and now it's come back

D : problem   yeah
P : again

D : what's what are we talking about what's the problem

P : well em it started off with redness around the gums along the sides

D : yeah   mm yes
P : there that seemed to you know irritate and itch and then it

D :   moved along   and you never had
P : it's gone along the front here

D : anything like this before

• P : no and um I've had them cleaned did you know

D : yes yes I've read your notes yes
P :   redness and sore all the time and straight-away after

D :   yeah
P : that it seems better   but then it gradually comes back again

Consultation 26:2

The consultation commences in a manner which does not differ too greatly in basic structure from those which have already been discussed. Initial prompting from the dentist ("what's been going on" and "can you bear to tell me about it") leads to the patient's indirect report of her problem. The technique which this patient employs, however, differs from those used by the patients of the two previous consultations. In this case, the patient responds by describing the beneficial results which she has experienced from a certain type of treatment which, in the past, has been administered whenever she has suffered from symptoms similar to those which are now troubling her (but which, for the moment, remain undescribed). The indirectness of this report is familiar to us, although the complexity of this indirectness is something new. In response, the dentist is obliged to ask a series of three specific questions ("yeah well what's the actual problem", "yeah what's what are we talking about" and "what's the problem"). To these three questions the patient replies with a description of the symptoms which are troubling her ("redness around the gums along the sides there that seemed to you know irritate and itch").

At this point an interesting development takes place. The dentist asks whether the patient has ever "had anything like this before". Quite clearly, if the patient's initial indirect report is to be considered valid she must have experienced "something like this" at least once before. However, the patient answers with a curt "no" and then immediately returns to what is obviously her main concern - cleaning - by asking her dentist a question ("and um I've had them cleaned did you know") and repeating her observation concerning the benefits to be had from cleaning ("and straightaway after that it seems better").

The consultation continues for some minutes with a series of questions from the dentist concerning the duration of the symptoms. The following episode then occurs.

(15)

D : yeah and uh despite all the visits you've had there's
    real no there's

D : been no big significant [improvement
• P :   [well one spell after a scaling

D :   [mm
• P : it seemed to ease off a lot [and then after about six or

P : seven [weeks it started to come back again
D :   [mm

D : mow what uh sort of things have you been doing about it

D : have you rubbed anything on or used a mouthwash
P :   (not) used toothp-

Consultation 26:2

The patient's concern with having her teeth cleaned again is now even clearer. However, from this point onwards the dentist pursues the possibility that there is something underlying the frequent reoccurrence of the symptoms and that it is this which should be tackled. The patient's attempts to have her dentist's attention focussed on the same matter as occupies her own attention have not yet been successful: The dentist completely ignores the question of cleaning.

Several minutes later, having examined the patient, the dentist describes the symptoms which he has observed.

(16)

D : well they look just a little sore an' raw just here now
P : mm

D : tell me is this a sore area just here

P : mm

((pause))

Consultation 26:2

Again, a few minutes later, the dentist describes what has been observed, but refrains from making a diagnosis.

(17)

D : they're all just a little sore there aren't they
P : mm mm

((pause))

D : mm hmm open for me now

((pause))

D : good well looking in your mouth there's not as you say a lot to see is there

P : no

D : I think just on the side of one tooth there where the tooth behind the one you've had a filling in there's a little notch in there which makes cleaning difficult and you could put a little filling in there but as you say the gums are very slightly red all the way round

P : mm

D : now have we um done any special tests ((etc.))

Consultation 26:2

Although the consultation continues for another quarter of an hour or so after this point, it can now be seen that the dentist has, at last, reacted to the patient's reports in a manner which is very similar to that employed by the dentists involved in the two earlier consultations. That is to say, the symptoms which the patient describes are not totally ignored and are not contradicted in the way that a self-diagnosis may be, but they are minimised almost to the point where they might be said to be trivial ("just a little sore", "just a little sore there", "there's not . . . a lot to see" and "the gums are very slightly red all the way round").

During the next stage of the consultation the dentist describes what tests he wants to have performed, and then prepares to put a filling into the "little notch" which he has identified. The patient uses this as yet another opportunity to bring up the matter of cleaning.

(18)

D : um now shall we do that little filling ((coughs)) now

{P : yes please yes ( )
{D : hmm let's have a local well do I I suppose

D : I do the same again really it's a minute amalgam I want
to do but just let's pop a local in you've had injections
before haven't you

• P : yes would you clean you the when you know the the

{D : {mm the electric toothbrush yes
{P : um electric {brush toothbrush yes

• P : would you clean along them with it or would you not

D : um d'you mean shall I now or well uh w- d'you mean the
P : mm

D : um d- the uh scaling device the electric yes oh I see
P : no the rotary

D : yes yes I can certainly clean round if you think that
P : you know

D : helps
P : mm I think it does

Consultation 26:2

This time the patient is more hesitant about discussing the subject ("would you clean you the when you know the the um electric brush toothbrush"). Eventually she makes her request indirectly in the form of a question which itself contains a conditional verb and which is supplemented with a negative tag, so allowing the dentist an 'escape route' if he needs one ("would you clean along them with it or would you not"). In fact the force of the question is so weak that the dentist has to rephrase it to check that his interpretation is correct ("um d'you mean shall I now"). Finally, the dentist accedes to the patient's request ("yes I can certainly clean round if you think that helps"), but for the time being takes no action in response to it.

Towards the end of the consultation, when the dentist is talking about "final rinses" and signing forms, but still no action has been taken to clean the patient's teeth, the patient again, for the fifth time, brings up the subject.

(19)

D : good yeah now we'll repeat the blood count

((pause))

D : 's just fill all these in

((pause))

• P : p- could you not do that um

D : I'll polish round for you in a moment   have you got a a
rubber cap and some (pummels) please

((pause))

D : now w- get those all finished off for   can you fill all
those bits and pieces in and we'll see the patient in uh
how long do they take to do they take quite a while

D : 'cause   they go over do   oh well
DSA: I think it's about a week a week and a half

D : two weeks then   let's polish round then with the magic
is that the stuff or is it the

D : pink stuff you normally have   well let's see
P : no   I don't know

D : ((chuckles)) let's you rest your head back you never get
P : ((chuckles))

D : round to see it

Consultation 26:2

And so, twenty-eight minutes after the consultation commenced and the subject was first introduced, the patient at last receives the treatment which she feels she requires.

This consultation is more complex than the two analysed at the beginning of this section, partly because it is so much longer. This in itself means that the patient enjoys more opportunity to repeat her request than if she were participating in a brief five or six minute consultation. The consultation is also made more complex, however, because the patient and the dentist are negotiating over two separate problems: the symptom of sore gums and the perceived need to have the teeth cleaned. Firstly, as in the earlier consultations the dentist apparently minimises the seriousness of the sore gums even when he at last acknowledges the symptoms. (Nevertheless he arranges for the patient to undergo an extensive series of tests which are related to this soreness). Secondly, the dentist ignores the patient's efforts to bring the possibility of having her teeth cleaned to his overt attention until her fourth attempt. The usefulness of the treatment is, even then, minimised ("if you think that helps").

We have been arguing in this section that the characteristics of patient-initiated consultations are as follows:

(a) The patient describes his complaint indirectly, by referring to the event which caused it, by describing his affective reactions towards it, or by discussing the sort of treatment which he has found to be appropriate for similar complaints in the past. However, until prompted by the dentist he will not describe precisely what his symptoms are (and may in fact never do so).

(b) The dentist reserves judgment on the patient's description of his own complaint but will, eventually, dismiss it by ignoring it altogether, by announcing it to be inappropriate or incorrect, or by minimising its importance. His response is frequently made in an indirect manner.

There has been no opportunity to give detailed consideration to the data from the hospital examinations department in the light of these findings. Nevertheless it would appear to be generally true that patients describe their symptoms or their complaints indirectly, and avoid reference to the pain or discomfort which has prompted them to seek treatment. The hospital data also, in large part, seem to substantiate the claim that the dentist delays acknowledgement of or response to the patient's self-diagnosis. When the dentist announces his own diagnosis it may be basically identical with the patient's original version, but will be rephrased and the similarity will not be acknowledged. Alternatively, the dentist's diagnosis may differ from the patient's in which case the patient's version will probably be dismissed.

6 : 6 THE PATIENT'S SELF-DIAGNOSIS AND THE DENTIST'S RESPONSE: SUMMARY

In sections 6 : 3 and 6 : 4 above it was observed that a patient returning to his dentist for a further stage in a continuing course of treatment can expect not to be invited to bring to his dentist's attention any new symptoms. However he may sometimes be invited to comment on the most recent treatment which he received. This appears to be the case in the majority of consultations which take place in both general practice and hospital treatment departments.

In section 6 : 5 it was found that when a patient attends for treatment with a new complaint he may volunteer information or he may be asked by his dentist to explain why he is attending. However, it is highly likely that the dentist will withhold judgment on the patient's description of his own symptoms or his self-diagnosis. There may be no further reference to the patient's diagnosis at all, or, at a later stage in the consultation, the dentist may dismiss it as erroneous or trivial.

These two sets of findings are complementary. They also fit well with the claim made by several dentists (referred to in section 6 : 1 above) that a verbal examination of patients was often unnecessary and that a simple inspection of the patient's mouth was generally sufficient. The asking of questions was, for these dentists, a cosmetic exercise.

But the dental consultation does not take place in silence. The dentist may provide his audience (patient and DSA) with a running commentary on the work he is carrying out. There may also be considerable discussion of matters which are totally unrelated to the patient's symptoms or treatment. Byrne and Long (1976), in their discussion of the verbal behaviour of general practitioners in their surgeries, consider it particularly noteworthy that patients occasionally discuss non-medical matters with their doctors. They list the relative merits of various gas cookers, the dubious paternity of a patient's neighbour's children, and whether or not Greece is a good place for holidays, as some of the "odd" topics "which have been put to unsuspecting GPs" (p 194). In the dental surgery, however, this sort of behaviour is not noteworthy: it is routine. One dentist, for example, in the course of a morning's work during which he treated five patients, discussed a patient's holiday in Palma, using a sunlamp, the weather (twice), a patient's beer drinking, a patient's planned business trips to Scotland and Malaysia, the chemical constitution of amalgam, the manufacturers of amalgam, the dentist's own recent bout of flu, the dentist's LandRover, how the dentist has painted his LandRover in black and white stripes, parking problems, the dentist's cleaning lady, a patient's experience in setting up business on his own, a patient's pregnancy, a patient's unwillingness to work in the Middle East, a type of pump manufactured in Birmingham, the standard of living in Britain, a patient's family, a patient's desire to visit Indonesia, and the strange orange flavour of mouthwash.

In summary, at one extreme the patient may be given no opportunity to review the state of his dental health, or, if he does report new symptoms, the dentist's response to this report may be dismissive. At the other extreme, there may be considerable discussion of matters not related to the patient's dental health. What is significance of these findings?

In section 4 of this report it was suggested that for many dental patients the overriding impression of the dental consultation is one of being unable to talk. However it was shown that patients (and their dentists) do in fact do a lot of talking during the consultation. It was argued, then, that this paradox could be explained by reference to preconceptions concerning the discoursal rules which are to apply and which patients bring with them to the consultation.

These preconceptions concern matters such as relative distribution of time for talking among participants, the absence of physical constraints upon talking, and the interpretation of questions. Preconceptions of what to expect in conversation are entrenched at so fundamental a level that the slightest transgression (e.g. a slight misbalance in the distribution of opportunities for talking) may achieve considerable prominence in the perceptions of the 'injured party'.

We are now in a position to suggest that the perceived lack of opportunity to talk is not related to the total amount of actual talking which occurs during the consultation. It is, rather, related to the talking associated with the symptoms which the patient feels he is suffering from. That is to say, apparent disregard or rejection by the dentist of the patient's self-diagnosis may constitute, for the patient, a very considerable infringement of the normal discoursal rules. This, then, achieves greatest prominence for the patient, to the extent that talk concerned with other matters fades into insignificance in the patient's perceptions. In this way the dentist's dismissive response to the patient's naive self-diagnosis contributes to the patient's perception that he says nothing throughout the consultation.

6 : 7 INDIRECTION IN PATIENTS' REPORTING

In section 6 : 2 above it was suggested that patient-initiated consultations commence with a situation in which 'patient knows all' and 'dentist knows nothing'. In section 6 : 5 it was found that a characteristic of these consultations is that the patient justifies his presence indirectly, not by referring to the pain or discomfort which he is experiencing, but instead by discussing his affective reactions to the pain, or by describing the event which he believes caused the pain, or - most indirectly of all - by discussing treatment which in the past has been found to be effective in reducing pain similar to that which is being presently experienced.

Dentist-initiated consultations - those which commence with a situation in which 'dentist knows all' and 'patient knows next to nothing' - were discussed in sections 6 : 3 and 6 : 4. Here it was demonstrated that the patient who does attempt to report new symptoms does so in ways which are curt and direct. He may exploit an enquiry from the dentist concerning his most recent treatment or he may introduce the subject of his new symptoms apropos of nothing, without any attempt to relate this subject to foregoing themes of the conversation.

Labov and Fanshel (1977) have identified three modes of direction or indirection in conversation. The first of these is the mode of expression, which is the way in which text and cues are related. The second is the mode of argument, which is the way in which propositions are embedded in the expansion. The third is the mode of interaction, the way in which 'what is said' is related to 'what is done'. They comment:

> We have no baseline for the total amount of indirection in ordinary interaction, but current studies of unmonitored conversation indicate that it is very great. The dimensions of power and solidarity are important determinants of the degree of indirection. Requests to superiors are necessarily mitigated, and one way of mitigating is to use extremely indirect modes of argument and interaction. (pp 67f)

It is argued that indirection is particularly common between strangers and between those who know each other with very great intimacy, in the former case so as to avoid conflict, in the latter because a great deal of information is shared. Elsewhere Labov and Fanshel add:

> . . . Many questions or challenges may be mitigated and performed so indirectly that no explicit reference to particular events is made at the time. Later reference may be made to these implicit questions or challenges by acts that are themselves very indirect. . . . The abstract nature of speech acts forms a necessary protection against direct confrontation between speakers of unequal status and competing views. (p 127)

Thus indirection is a technique which seems to be frequently employed in conversation between inferiors and superiors, between strangers, and between intimate acquaintances. Patient use of indirection has been observed when symptoms are being described at the beginning of patient-initiated consultations. Dentist use of indirection has also been observed when the 'official' diagnosis is announced in the same consultations. For both patient and dentist, then, the normal conversational rules appear still to apply in patient-initiated consultations to the extent that indirection may be utilised to mitigate the force of a request (from a patient) or the announcement of bad news (from the dentist).

In dentist-initiated consultations, however, the situation changes. For the dentist, the rules are no different and indirection is still employed if and when a diagnosis is announced. But the patient can no longer employ indirection if he wants to bring new symptoms or a new condition to the attention of the dentist. The only way to introduce the subject is to be direct.

The extract which follows illustrates inappropriate patient use of direct techniques. The consultation is third-party-initiated and takes place in a treatment department of a dental hospital. Normally, in such circumstances, as in patient-initiated consultations, the patient would be allowed and expected to describe her symptoms indirectly. However this patient chooses to be extremely direct.

(20)

D : well now so it's gum troubles what sort of troubles have you had yourself

P : what sort of

D : gum troubles have you had

P : er well this has started about four years ago and I went
D : mm

P : to the dentist in Liverpool in fact I been to a couple and been treated for

P : it with tablets they've cleaned and scaled me teeth and gave me
D : yes

P : the (Boccason) powder

D : yes

P : and while I've taken the tablets and used the powders it's
(okay really)
D : everything's okay

P : and then as soon as I stop it comes back again cause c's that
D : yeah what comes back

D : back soreness bleeding what

• P : erm it they bleed when I brush me teeth

D : mm hmm

• P : I also have a vile taste in me mouth and it seems to be centred round the one tooth

D : mm hmm up there mm
• P : it's it's a terrible taste and me breath smells and all

• P : the gums sort of are red you know inflamed and all me gums are receding

D : they're shrinking back and you've noticed the teeth getting
P : longer

D : longer and longer which teeth are they all round down there
P : yes mm mm

D : particularly well now let's ah
• P : yeah and I can lift me gums with me nail

D : can you

P : you know under me teeth and I've got gaps between all the top ones I think the top gums are going as well

D : so you're in a bit of a state then

P : yes

Consultation 26:3

The transcript fails to reveal the speed and intonation with which the patient delivers her medical history. Although the consultation does, to some extent, begin in a typically indirect way and apparently has to be made more specific by the dentist ("yeah what comes back soreness bleeding what"), in fact the speed with which the patient describes the background to her complaint and then lists the extraordinarily precise series of symptoms indicates that the background history and the list of symptoms have been conceived as a whole. The dentist's questions are treated by the patient as interruptions, rather than as prompts. It might be imagined that this rapid and concise presentation of symptoms would be an efficient way of starting a consultation. In fact it is so unusual that it seems to take the dentist aback.

The unusually direct way in which the patient of Consultation 26 : 3 presents her symptoms and the dentist's suprised response to the presentation provide an indication of the strength of the conversation norm that symptoms may - and should - be presented indirectly in patient-initiated consultations. (Third-party-initiated consultations may be grouped with patient-initiated consultations for this purpose, since at the commencement the situation is that 'dentist knows almost nothing' and 'patient knows almost everything'). A direct technique is appropriate only in dentist-initiated consultations, where it is the only means by which the patient can introduce new symptoms to the attention of his dentist.

APPENDICES-

7 : 1 DENTIST AND PATIENT QUESTIONNAIRES

7:1:1: NEED FOR QUESTIONNAIRES

To summarise, from the beginning there appeared to be a lack of fit between the stereotypical response which people have towards communication with their dentist, and the most immediately conspicuous characteristics of that communication as observed during preliminary data collection. It was hypothesised that this lack of fit might in itself be of some interest and significance to our investigation. Quantifiable data concerning the actual frequency and degree of patient and dentist contributions to dentist-patient talk were available in the audio-recordings of dental consultations. But, for the apparent lack of fit to be analysed thoroughly, quantifiable data concerning patients' and dentists' perceptions of the frequency, degree and variety of their contributions would also be required. These could be obtained not by direct observation but only by questionnaire or interview.

Ultimately, then, a comparison will be made between the perceived frequency, degree and variety of patients' and dentists' mutual participation in discourse (as revealed by questionnaire) and the actual extent of their participation (as revealed by observation and the recorded data). A similar comparison will need to be made between a). patients' perceptions of the infrequency with which they are given explanations of the treatment they are receiving, and b). the actual frequency of the explanations they receive. A further comparison will be made between a). patients' perceptions of the likelihood of being invited by their dentists to make verbal responses when there are physical constraints upon their doing so, and b). the actual frequency of their being obliged to make a verbal response in difficult circumstances.

Clearly, the frequency with which patients contribute to dentist-patient talk does not equal the frequency of their dentists' contributions. Also, it is certainly true that patients are sometimes not told precisely what treatment they are receiving or why they are receiving it. Finally, as was shown in section 6 above, it is also true that patients do occasionally experience the difficulty of feeling obliged to make a verbal response when they are physically unable to do so. Nevertheless, our present hypothesis is that, in absolute terms, each of these phenomena actually occurs far less frequently that the perceptions of patients suggest.

Now if it should turn out that this hypothesis is substantiated, we will be obliged to seek an explanation for it. Why should it be that patients feel that they have considerably less opportunity to speak than they really do? Why is it that patients feel that they are rarely told what treatment is being administered to them when in fact their treatment is explained to them more often than not? And what is it that makes patients feel that they are often unable to reply to their dentists when actually this happens only rarely?

7:1:2: RELATIONSHIP BETWEEN PERCEIVED AND ACTUAL LANGUAGE USE

Before we attempt to posit answers to these questions, it will be valuable to consider what evidence there is that perceptions of language use may differ from observable behaviour.

The literature of social psychology contains numerous instances in which self-report data have been shown to be an unreliable guide to actual performance, and in which subjects' perceptions of phenomena in the immediate environment differ significantly from the reality of those phenomena as evaluated by an objective assessment. Shaver (1977) says:

> "The perceiver constructs social perceptions out of the stimulus information given, categorizes stimulus persons according to their criterial attributes, and interprets social behavior and social situations. Interpersonal accuracy increases with the perceiver's intelligence, cognitive complexity, experience, and empathic ability . . . . But perceivers are not always accurate. As a result of an active interpretation of the social world, the perceiver may make certain kinds of errors. What perceivers look for in other people will be determined in no small degree by their implicit personality theories; . . . . and their

> interpretations of particular social situations may be influenced by their temporary needs or motivational states".
>
> (p. 149)

This failure of the perceived to coincide with the actual is especially likely to occur when the phenomenon or behaviour in question is associated in some way with a variable which has high positive or negative affective value in the community of which the subject is a member.

Seeman (1972), for example, has shown that pupils in an all-Negro school in the United States not only over-estimated the degree of lightness of their own skin colour, but also evaluated light skin colour positively. A further example is provided by Kephart (1972), who showed that eighty-seven per cent of white policemen in Philadelphia overestimated the percentage of arrests involving Negro citizens which took place in their own police districts. Furthermore, the degree of overestimation of the Negro arrest rate increased as the actual Negro arrest rate increased. Finally, Kephart found that 91% of the white policemen overestimated the number of their Negro colleagues working in the same police force at that time.

Similar findings have been made in relation to perceptions of language use. It has been shown by Lambert et al. (1972) that French-speaking Canadians allow greater positive value to the English language and to speakers of English than to their own language or those who speak it. Meanwhile, Coleman (1980) found that Indonesians, working in an isolated community centred on a mining operation in which expatriates maintained a particularly high profile, claimed to use English in 67% of their spoken contacts at work with expatriate colleagues. Yet, in a similar community a few miles away, in which the 'visibility' of expatriates was considerably less, Indonesians claimed to use English in only 42% of their relationships with expatriates at work. Furthermore, in the former of the two mining communities, expatriates claimed that, in their spoken relationships with Indonesians at work, they used Bahasa Indonesia ten times more frequently than their Indonesian colleagues did when speaking to them.

There is, then, already sufficient evidence with regard to language use and other aspects of social behaviour, that perceptions may not equate with reality. More interestingly, the type and degree of this lack of equation may in themselves be revealing and significant phenomena.

7:1:3: 'MEANS OF SPEAKING': UNEQUAL CONTRIBUTIONS

In section 7:1:1: above it was hypothesised that there are 'exaggerations' in the perceptions of dental patients concerning a). the share which they are normally allotted in dentist-patient talk, b). the rarity with which they are informed about the treatment they are receiving, and c). the frequency with which they are physically constrained from responding to discoursal acts which in normal circumstances would require a response. It was seen, in section 7:1:2:, then, that it is not unknown for perceptions of behaviour or of phenomena in the social environment to differ form actual behaviour or from an objective assessment of those phenomena.

Of primary interest to us in our search for a plausible hypothesis to explain the apparent lack of fit between actual performance in dentist-patient communication and patients' perceptions of that communication is the 'operating principle' concerning the allocation of time in conversation among participants. As yet, linguists have given little attention to this particular aspect of the means of speaking.

7:1:4: HYPOTHESES AND QUESTIONS

(a) DISTRIBUTION OF TALK

Our argument is here, that one of the operating principles which speakers expect to find functioning in the normal dyad encounter is that the distribution of talk between the two participants will be approximately equal, and certainly no more extreme than 60% - 40%.

Although no statistical analysis has been made as yet, it is apparent from the data that in dentist-patient contact the distribution of talk exceeds these limits quite considerably. That is to say, patients (and dentists) bring with them a 'discoursal set', a set of preconceptions about what discourse with the other member in a two-member group normally involves. One of these preconceptions is that their share of the talk (even in situations where they acknowledge the superior rank of the other member) should not be less than approximately 40%, or greater than approximately 60% of the total. In the situation of a dental consultation, however, this discoursal set is inappropriate. The 'means of speaking' which operate in the dentist's surgery are not the same as those which operate outside. But for the patient a transgression of the conventions with which he is familiar - even a relatively minor transgression - may be interpreted as a gross infringement on his rights as participant. That is, even though the patient does actually enjoy some opportunity to speak his perception may be that he is being granted no opportunity whatsoever, or only an extremely limited one, simply because his firmly entrenched and constantly reinforced expectations have, for once, not been fulfilled.

The foregoing is, needless to say, entirely hypothesis. But it is the eventual confirmation or refutation of this hypothesis for which the questionnaires, supplemented with interviews, will be required.

Meanwhile, a phenomenon frequently encountered in patient response to enquiries from the dentist may be adduced in partial support of our argument that patients bring inappropriate discoursal sets with them to their dental consultations.

There are instances in the data of a patient responding to the dentist's questions as though these questions were 'conversational', when in fact the dentist simply requires information about the patient's medical history or present condition. Consequently an enquiry, which in the context of the dental consultation requires a purely factual reply, may be treated as a conversational cue.

This is seen in item (1):

(1) D : ye that's tha' that's your problem I'm going to look at that
in just a moment but I need to find a little bit more about
you in general

D : first of all you know um let me see wha w
P : yes

D : what's your health like in general you look a good healthy

D : person to me I
P : yes I have been until three months ago and I got
bronchitis and I've never had it in my life and it took me
D : yeah

• P : three it's taken me three months to get over it which still

P : left me with bronchial catarrh and I am a healthy person
D : you

D : you look healthy you eh ye e yes yes
• P : I can't understand why this I couldn't get

• P : over this bronchitis it's that nasty virus attack do
D : yes eh yes yes

• P : you remember everyone had it
D : yes yes I remember so tha' so you've had bronchitis

D : have you had anything in the past like rheumatic fever or
diabetes

• P : no I've never had bronchitis in my life
D : no nothing at all

(Observation 25 ; Dentist (male) in hospital prosthetics department
and patient 1 (elderly female); Liverpool; 16 June 1980)

Item 2 is a further illustration of the patient's tendency to treat the consultation as a conversation ("I just thought I'd mention it"). It also reveals, however, that in the consultation preceding the present one the dentist has failed to extract all relevant information from the patient. The patient apparently interpreted the earlier consultation not as an information-exchange session. but as a conversation, the rules of which allow each participant to select and edit the information which is given to the other member:

(2)

D : no well shall we start on the lower left side then or do you usually have injections for doing that your drillings and things

P : yeah (s) depends if you're gonna do a lot or not

D : er in your mouth I'm gonna do a lot

P : not today though are you

D : no not necessarily you are you suggesting you'd like to see
P : (   )

D : how you go without an injection

P : no I'll have an injection

D : yes why not (but) you don't like injections

P : no sometimes I get a one of these valium things you see

D : sometimes you get one of these valium things what d'you mean

D : by a valium thing
P : a valium drug and all

D : do you

P : yeah

D : you didn't mention that last time did you

P : but I can do with just if it's just fillings I can get

{D : {d'you are you telling me that the fillings you've had done
{P : {(   )

D : were done while you were having an intravenous {anaesthetic
P :   {yes

D : were you ah that probably account for a lot of the problems doesn't it see the problem is that if you're gonna have erm er a general anaesthetic there's always a hurry to get you conscious again

P : is there

D : yeah and that's why probably finishes up with having things not quite completed and things like that and I ain't gonna do that

{P : no it's {alright then
{D :   {mm   that's alright oh thank you very much

{P : (I just thought) mention it you {know
{D :   {I see

(Observation 21; dentist (male) in private practice and patient 5 (teenage female); Southport; 16 May 1980)

We have suggested, then, that patients frequently take with them, to their dental consultations, discoursal sets or operating principles which are inappropriate as regards both the quantity (distribution of participation) and the quality (interpretation of questions) of the discourse. Levinson (1979) has developed an argument for the notion of activity types which may be illuminateing here. Activity types refer to a fuzzy category, the members of which are goal-defined, socially constituted and bounded events which have constraints on participants, on setting and, in particular, on allowable contributions from the participants.

(op. cit. p.368) Levinson says:

> ". . . Types of activity, social episodes if one prefers, play a central role in language usage. They do this in two ways especially. On the one hand they constrain what will count as an allowable contribution to each activity, and on the other hand they help to determine how what one says will be 'taken' - that is, what kinds of inferences will be made from what is said".
>
> (p.393)

Now it is not difficult to see the dentist-patient consultation as a very clearly defined activity-type, with easily identifiable participants, setting and goals. It should not be too difficult (for us, as third-party observers) to identify also the constraints on allowable contributions in this activity. However, Levinson acknowledges that the task of identifying the activity one is involved in may not be so simple for the participants themselves:

> "A final issue that arises . . . can be a very real interactional problem that faces conversationalists: How does one ascertain which activity one is in at any one point in an on-going interaction? Sometimes the gross facts of physical setting, time, copresent personnel, etc. are insufficient to determine the activity. . . . A good locus for the study of such activity-identifying processes is where misunderstandings arise due to different cultural or subcultural origins of participants".
>
> (p.395, note 7)

We are proposing that whilst the 'gross facts of physical setting' and so on are sufficient for patients to determine which activity they are involved in, nevertheless (perhaps because this type of activity is experienced very infrequently) patients can encounter difficulty in identifying and employing appropriate strategies for communication, and in making contributions which are always and only allowable ones. It is this, we believe, which underlies the perceptions which patients report of not being allowed any opportunity to contribute to the talk which takes place during consultations.

(b). 'MEANS OF SPEAKING': INFORMATION AND PHYSICAL CONSTRAINTS

Our attention has, so far, been directed mainly at the problem of the lack of fit between patient perceptions of the share which they are normally granted in dentist-patient talk and the objective reality of dental consultations. Two further problems remain. The first of these concerns patients' complaints that dentist rarely explain what treatment is being administered. This will be dealt with more fully in (c) below.

The second problem associated with patient perceptions is the complaint that dentists expect patients to respond, even when they are physically constrained from doing so, to discoursal acts which in normal circumstances would require a response. It has been shown that patients do, indeed, occasionally find themselves in situations of this type. Nevertheless (although no quantification of the recorded data or of patient perceptions has been attempted yet) our thesis is that the perceptions will ultimately be seen to 'overstate' the case. Again, the question to be answered is why this anomaly should ever occur.

Our hypothesis is that the factors responsible for perceptions of the unequal distribution of opportunity in dentist-patient talk can also be considered to underlie perceptions of frequent physical constraint upon participation. That is to say, in normal circumstances participants are rarely inhibited from making appropriate responses or initiating relevant contributions because of the presence of foreign matter in the mouth. In many cultures, including modern British society, the politeness maxim which forbids speech when the speaker has food in his mouth is felt by many individuals to be weaker than the discoursal rules which demand a). that a question be immediately replied to, and b). that there must be no gaps between speaker turns. (These rules are stated formally in Sacks, Schegloff and Jefferson (1974) and are summarised here as follows:

> a) ". . . addressing a question to a party selects that party as next speaker"
>
> (p. 29)

> b) "Transitions (from one turn to a next) with no gap and no overlap are common. Together with transitions characterized by slight gap or slight overlap, they make up the vast majority of transitions".
>
> (p.18)

The force of these rules is felt so strongly that, wherever possible, participants will attempt to keep them. Any external, uncontrollable constraint which inhibits the execution of these rules will, therefore, achieve considerable prominence in the perceptions of those who are affected by it. Consequently, although this constraint actually applies relativley infrequently during consultations, it is perceived as being a significant factor in those consultations.

(c). APPREHENSION AND THE DISTORTION OF PERCEPTION

The preceding discussion has been concerned with questions which arose at a very early stage in the investigation when it became apparent that those characteristics of dentist-patient communication which are of considerable significance to patients seem (to neutral observers at least) to have less prominence when assessed in the context of the total pattern of communication between dentist and patient. Here, however, we shall look briefly at a problem which was not immediately apparent but which was brought to our attention by Professor W.M. Oliver, Professor of Dental Health at Liverpool. The problem is basically that of discovering why it is that patients tend to neglect oral hygiene and only rarely implement the advice which they are given by their dentists.

There can be no doubt that dentists do give liberal doses of advice to their patients, as Items (3) and (4) illustrate:

(3). D : good girl that's it you can have a rinse round now (I) might
just remind you that the top right hand side is not getting

{D : as well brushed {as it should be erm on the palate side the
{P :   {mm

D : inside of the teeth rather a lot of gubbins were stuck around
there and I suspect it's only because you've developed some

sort of habit which tends to leave that bit out most people
• brush more by habit than anything else and er (s) suggests

D : that for the next little while you think about starting on
that top
P : mm

• D : right hand inside edge stead of probably making it the end
P : (mm)

• D : of the line when you've just about finished okay er this has gone I've no doubt jolly numb so let us see could you turn to your right a little bit thank you

(Observation 22: Dentist (male) in private practice and patient 2 (adult female); Southport; 16 May 1980)

(4). D : d'you smoke cigarettes

P : mm

D : not many

P : I've given 'em up now

D : you're giving 'em up now are you

P : they're going up soon ((laugh))

DSA: ((Laugh))
D : ((Laugh)) yeah: they're very expensive aren't they

((5 seconds))

D : just relax your lip alright

((7 seconds))

D : mind you you'll still get tartar even when you give your cigarettes up the cigarette nicotine will stain the tartar brown makes it look nastier but it will still form you'll

• have to brush just as hard even when you give up your cigarettes as you do before

P : mm

D : because tartar isn't formed from cigarette smoking the tartar gets stained from the cigarette smoking it doesn't look so good I must admit

((8 seconds))

• D : Your teeth are not bad you know (you wanna) look after these teeth

((6 seconds))

• D : when you brush your teeth at home don't be frightened to make your gums bleed a lot of people are

P : mm

D : amd they shrink at the sight the first drop of blood

{P : [(   )
{D : [(yeah)   you shouldn't worry because quite honestly you've
• got to brush the gums as well as the teeth to do a good job of brushing your teeth you can't brush teeth properly without touching gums that's what a lot of people try to do and it doesn't work and you can always tell because there's a little ring round the edge of the tooth near the gum which has got (soft) food on it still or else decarcification like on that tooth there and that tooth there decarcification just means that the tooth looks chalky you know bit white (yellowish)

{D : round the neck (   )
{DSA: does that develop

D : hm

DSA: does that just develop

D : it comes under (material) (   ) material (   ) (on the front) washed away you see there there (won't) go away now always be there but if you keep it really clean it won't get soft that's the point and it won't need a filling in it

(Observation 6 ; Dentist (male) in general practice, dental surgery assistant (female) and patient 7 (male child); Morecambe; 21 March 1980).

The prolixity of the advice-giving in Items (3) and (4) is not unusual. However, it should be observed that advice of this type is very often given while the dentist is at work treating or examining the patient.

Our initial hypothesis - again one which can be partly tested through the questionnaire - is that the apprehension or actual experience of potential discomfort or pain narrow the focus of attention of the patient to such an extent that later there is little recall of what has been said to him, and in particular what advice he has been offered.

It was particularly striking, throughout the observation and audio-recording sessions, that many patients seemed hardly to notice the presence of the researchers. Similarly, the audio-recording equipment, although not concealed, attracted very little attention from patients. This circumstantial evidence may be interpreted as corroborating the suggestion that the stressfulness of the situation reduces patients' attentiveness quite sharply.

In the recorded data there is also some evidence that patients' ability to absorb what is said to them with regard to the treatment they are receiving or about to receive may be clouded because of anxiety. This appears to be the case in Item (5):

). D : right well I've taken all the amalgam out of these two but unfortunately there's a bit of de- well quite a lot of decay in fact underneath those fillings and it's gone down to the nerve so what we'll do we'll have to take this back one out we can't really save that for you the one in front of it we're going to put a temporary filling in and see how it goes if you have any pain or trouble from that then you'll have to have that one extracted as well if not then we'll put a permanent filling in for it and see if we can hang onto that one so I'll

{D : do that now I'll put the temporary filling   in the front
{P :   (mm)

D : one in the back one we'll take you downstairs and get that out while it's still anaesthetised okay

((6 minutes 25 seconds))

D : right let's switch that off now have a good rinse out

((40 seconds))

D : right (   ) just wait there for a couple of minutes while I write all this up and then you can come downstairs with me alright

• P : yeah (.   out today)

D : pardon

• P : gonna take it out today

D : that one at the back

• P : (no next week no)

D : well it might as well come out now while while it's under an anaesthetic rather than next week you have to come in and then have it anaesthetised again

((30 seconds))

D : (pardon) er not really

((1 minute 20 seconds))

• P : is the is is it top one

D : pardon

P : is it top is it top one

D : the back one is yeah that's the hole you can feel with your tongue

(Observation 16; student dentist (female) in hospital conservation department and patient (adult male); Liverpool; 12 May 1980)

More than seven minutes after the treatment plan is explained to him, the patient still requires confirmation that his tooth is to be extracted on that same day. Two minutes later he asks for identification of the tooth which is to be extracted. This suggests very strongly that the student dentist's initial explanation has been of little value to the patient.

At this point it is appropriate to return to the problem discussed under Hypotheses, in Section (c) above. This is the complaint from patients that dentists rarely explain what treatment is being administered. Items (4) and (5), however, are evidence that in fact dentists very often do explain what treatment they are giving or they plan to give their patients. Indeed these explanations are frequently extremely detailed. Again, our provisional hypothesis will be that it is apprehension of the prospect of pain, the stress of the consultation, which influences patients' perceptiveness to such a degree that they just do not notice much of what is said to them.

The work of social psychologists with regard to information intake has tended to concentrate on the problem of cognitive dissonance. Aronson (1976) describes this as:

> ". . . a state of tension that occurs whenever an individual simultaneously holds two cognitions (ideas, attitudes, beliefs, opinions) that are psychologically inconsistent.

> Stated differently, two cognitions are dissonant if, considering these two cognitions alone, the opposite of one follows from the other".
>
> (p. 88)

Because the occurrence of cognitive dissonance is unpleasant, it is avoided or reduced wherever possible. Take for example a situation in which there is dissonance between an aspect of one's behaviour and information presented to one which suggests that this behaviour is detrimental or disadvantageous to oneself or others. The dissonance which is aroused will be reduced by rejection or distortion of the evidence. Aronson says:

> "The deeper a person's commitment to an attitude, the greater his tendency to reject dissonant evidence. . . . People are not passive receptacles for the deposition of information. The manner in which they view and interpret information depends upon how deeply they are committed to a particular belief or course of action. Individuals will distort the objective world in order to reduce dissonance".
>
> (pp. 92f)

The concept of the reduction of cognitive dissonance suggests an almost culpable determination to avoid objective reality whenever it might lead to discomfort. A different approach has been taken by Evans et al. (1973) who have studied the impact of anxiety on reported and actual behaviour.

In part of a junior high school dental hygiene programme, groups of pupils were exposed to several different persuasive techniques, each of which had the aim of achieving changes in the children's dental hygiene habits. These persuasive techniques were a). high fear arousal, b). moderate fear arousal, c). positive affect arousal, d). elaborate recommendations, and e). brief recommendations.

The research team found very strong evidence that, over a six week period immediately following the exposure to the persuasive techniques, reported behaviour and actual behaviour did not correspond. That is to say, from examination of the children's teeth during the six week period it was possible to see to what extent self-reports on changes in teeth-cleaning habits were accurate. The investigation concluded that elaborate recommendations and positive affect arousal were the techniques most effective in changing *actual* behaviour, but that the techniques of high fear arousal and brief recommendations were most effective in changing *reported* behaviour.

These findings are relevant in that, firstly, they confirm one of the principles on which our hypothesis are based (that is, that reported and actual behaviour may be expected *not* to coincide in certain circumstances). Furthermore, though less directly, they suggest that, when patients are in a state of anxiety, their perceptions will be distorted. And finally, they lend credence to the argument that any advice on dental hygiene, albeit in the form of elaborate recommendations, will be ineffective if it is given at a time when patients are anxious or are actually experiencing physical discomfort.

We may summarise the hypotheses discussed above as follows, accepting that many if not all of them will undoubtedly require modification, amplification or rejection at a later stage.

1). It is hypothesised that patient perceptions of many aspects of the relationship with the dentist are distorted.

2). It is hypothesised that patient perceptions of much of what happens during the consultation are distorted.

3). It is hypothesised that patient anxiety caused by the apprehension of pain or the actual experience of discomfort is partly responsible for the distortion of patient perceptions.

4). It is hypothesised that patient anxiety caused by the 'transgression' of fundamental discoursal preconceptions during the consultation is also partly responsible for the distortion of patient perceptions. These preconceptions concern a) the distribution of talk, and b) physical constraints on talk. An alternative approach is that patients and dentists bring different and therefore mutually incompatible 'ways of speaking' to the consultation.

(d) ADDITIONAL QUESTIONS:

In addition to the particular hypotheses outlined in (a) to (c) above, and which arose from preliminary observations from our data and from conversations with dentists, there are specific further questions to which we seek answers from responses to the two questionnaires which follow. These questions are summarised below, although amplification and evaluation of them will, of course, have to wait until we have significant returns:

(1) Patient perceptions of the Ideal Dentist and the Ideal Consultation

a) What role does communication with the dentist play in the patient's perception of the ideal consultation?

b) What role is the dentist perceived as playing in the ideal consultation?

c) To what extent are these perceptions functions of age, socio-economic class, frequency of contact between dentist and patient, and duration of relationship between dentist and patient?

(2) Patient Perceptions of the Dentist in Reality and the Consultation in Reality

a) What role does communication with the dentist play in the patient's perception of the actual consultation?

b) How widespread is the belief that patients say nothing to their dentists?

c) To what extent is communication with the dentist perceived as being frustrating?

d) To what extent is the potential experience of pain perceived as an element of the consultation and the relationship with the dentist?

e) To what extent are these perceptions functions of age, socioeconomic class, frequency of contact between dentist and patient?

f) To what extent is the dentist himself perceived as being responsible for how the consultation develops?

g) What other factors influence the consultation?

h) To what extent are these perceptions functions of age, socioeconomic class, frequency of contact between dentist patient, and duration of relationship between dentist and patient?

(3) Patient Response to Advice

a) Is advice on dental hygiene perceived to be important?

b) Is advice on dental hygiene perceived as being implemented?

c) To what extent is the response to advice perceived as being influenced by the personality of the dentist, by communication with the dentist and by the nature of the consultation?

d) What steps are perceived as being essential for a dentist who wished to see his recommendations implemented? (Would he have to treat his patients as individuals? Would he have to talk to them more?)

e) To what extent are these perceptions functions of age, socioeconomic class, frequency of contact between dentist and patient, and duration of relationship between dentist and patient?

(4) To what extent do patient perceptions coincide with dentist perceptions?

(5) To what extent do patient perceptions mirror reality?

4 : DENTISTS' PERCEPTION OF ROLE IN THE CONSULTATION

(a) How much importance does the dentist attach to his various roles?

(b) How much importance does the dentist attach to the patient's role(s)?

(c) To what extent does the dentist vary his communication according to his understanding of patient type and the kind of behaviour he thinks particular patients expect?

(d) Do dentist prefer particular types of patients?

(e) To what extent is the dentist's measure of professional success or failure with a patient dependent on the success or failure of their communication?

(f) What is the nature of explanations given by dentist to patients?

7:4 SUGGESTIONS FOR FURTHER RESEARCH

It has been found that the relatively limited amount of data already available is extremely rich. Even in this report so far only the surface of these data has been skimmed and much work still remains to be done. The following are some specific suggestions for directions in which this, the work of the report might be extended. (see also the questions raised in section 7:1:4: above)

The process of history taking and detailed questioning of patients has not been examined closely yet, although it is clearly related to the processes which have been examined above in Sections 4, 5 and 6 of patient reporting of symptoms and dentist response to these reports. An important stage which occurs in many consultations is that of advice giving. It would be interesting to investigate how, if at all, dentist modify their advice giving from patient to patient and how the giving of advice is related to the ways in which patients report their conditions.

Further investigation is also required to determine other norms of inter-action in dentist-patient communication, how they vary from consultation-type to consultation-type and from context to context, and what effects are produced when they are broken. Most interesting will be a comparison between these norms, their contexts and their functions, and those employed in 'normal' conversation (outside dental consultations).

The effect of fear or apprehension of pain, or simply of awe, has yet to be studied. There are indications that fear or awe may influence the precision with which patients answer their dentists' questions and, even more clearly, that it distorts patients' ability to absorb and act upon the advice which they receive. A similar phenomenon has been observed in the courtroom. Max Atkinson (personal communication) reports:

> "I don't remember" is a recurrent reply in some cross examination sequences where the going is getting tough for a witness. This is particularly os in a case where the alleged victim in rape trial is being pressed about the details of the events which took place on the traumatic night in question. In other words, claims not to be able to remember are relatively frequently used resource for witnesses under such circumstances.

There is considerable scope for work at the level of vocabulary; for example how and why dentists employ or avoid technical terminology and how patients react to it; where the threshold of technicality lies for dentists and patients respectively. Some quantification of the frequency of events such as information extraction, advice giving, dentist's commentary on work in progress, discussion of non-relevant matters, and dentist-DSA conversation which ignores the patient is required. Ultimately it will be possible to compare much of this 'objective' data with patient perceptions of the characteristics of dentist-patient communication which will be revealed by the dentists' and their patients' attitude surveys (see the questionnaires in Section 7:2 and 7:3 above)

The data base of the research could usefully be extended to cover a greater number and a wider variety of general practice surgeries and their dentists. There may well be advantages in extending the survey over a wider geographical area.

Labov and Fanshel conclude their study of verbal transactions in a psychotherapeutic interview with the pessimistic observation that, despite an urgent need for one:

> . . . . it would be unrealistic to foresee a science of the study of conversation, or even the foundations of one.
>
> (p 360)

Nevertheless:

> The study of conversation is engrossing for us because we are all participants in the same practice. For better or for worse, conversation is the human way of dealing with human beings, and we find in it a fundamental expression of our humanity.
>
> (p 361)

It is appropriate that this preliminary stage in an investigation should close not with a summary of achievements but, rather, with this simple statement of why it is that the study of situated speech is so intensely interesting.

University of Lancaster

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Dear

Dentist-Patient Communication

General Dental Council Project:

Questionnaire

The General Dental Council has asked us to carry out a study of dentist-patient communication and to prepare proposals for English language tests for dentists from overseas, whose first language is not English, and who wish to practise in Great Britain. Our study has so far involved observations and recordings of a large number of consultations in different types of practise. We now wish to supplement this fieldwork with a survey of the attitudes of a number of dentists to communication in the dental surgery. We are particularly interested in the following topics which have arisen in our discussions with dentists.

(1) Do the perceptions that Dentists and their patients have about their encounters differ;

(2) Do dentists and patients perceive differences between desirable communication in the surgery and the communication that actually occurs;

(3) How do dentists vary their communication in the treatment of different patient-types?

We very much appreciate that, in a busy dental practice, you have little time to spare, but we would be grateful if you could complete the questionnaire attached to this letter. We realise that the questionnaire may appear long, but we find in practice that it should not take more than half an hour to complete. A stamped, addressed envelope is enclosed for easy return of the questionnaire.

If you would like to know more about the project or feel that there are other ways in which you could contribute, we would be pleased if you would contact us.

contd ...

Please be assured that your responses to the questionnaire will be treated as completely confidential.

Yours sincerely

Christopher N Candlin
Project Director

NOTE: The questionnaire which follows has developed from a number of pilot drafts and we are grateful to professional dentist colleagues for their advice and criticism. The questionnaire will be distributed and the results will form the content of a subsequent Annex to this report.

UNIVERSITY OF LANCASTER
GENERAL DENTAL COUNCIL PROJECT
DENTIST-PATIENT COMMUNICATION

Dentist's Questionnaire

7:2

A. How to fill it in:

There are 24 questions in the questionnaire. Please answer each one.

Most of the questions have three parts.

Many of the questions can be answered by putting a tick ☑ in the box by the answer which you think is most suitable.

Sometimes you are asked to write your own answers, to put a list of answers in an appropriate order, or to ring ① numbers. Instructions on how to answer those questions are given with the questions themselves.

B. Further Comments

If you want to explain your answers or make any extra comments, please use the space provided by the questions, or the back page of the questionnaire, or, if you wish, a separate piece of paper.

UNIVERSITY OF LANCASTER

GENERAL DENTAL COUNCIL PROJECT

DENTIST PATIENT COMMUNICATION

Dentist's Questionnaire

1. (i] Of the following roles which have been suggested for dentists, which do you think are most important?

a] to stop pain ☐

b] to prevent pain by treating dental disease at an early stage ☐

c] to calm and soothe apprehensive patients ☐

d] to educate patients so that disease can be prevented ☐

e] to provide specific treatment when necessary ☐

f] to make the patient feel that he is being treated as a person and not just as a case ☐

g] to protect the patient from the consequences of the loss of teeth ☐

(ii] Which of the following do you spend most time on generally?

a] stopping pain ☐

b] preventing pain, by treating dental disease at an early stage ☐

c] calming and soothing apprehensive patients ☐

d] educating patients so that disease can be prevented ☐

e) providing specific treatment when necessary ☐

f] making the patient feel that he is being treated as a person and not just as a case ☐

g] protecting the patient from the consequences of the loss of teeth ☐

h] other (please specify):

(iii) If there is any difference between your answers to 1(i) and 1(ii), which of the following reasons seems to be the most likely?

- a) patients are not interested in the kind of dental care that dentists want to provide ☐
- b) there isn't any time to treat and advise patients on better self-care ☐
- c) advice to patients on better self-care is not remunerated under NHS regulations ☐

2. (i) Should a dentist ask patients about the problems they are having with their teeth?

- a) Yes, at every visit ☐
- b) Yes, at the beginning of each course of treatment ☐
- c) Yes, sometimes ☐
- d) Yes, but only occasionally ☐
- e) No, never ☐

(ii) Do you ask your patients about the problems they are having with their teeth?

- a) Yes, at every visit ☐
- b) Yes, at the beginning of each course of treatment ☐
- c) Yes, sometimes ☐
- d) Yes, but only occasionally ☐
- e) No, never ☐

(iii) If you chose d) or e) for 2(i) and/or for 2(ii), to which of the following reasons was your choice due?

- a) Not all patients can describe their dental problems ☐
- b) Usually, a dentist will find any problems while he is inspecting patient's teeth ☐
- c) Some patients are too nervous to be able to answer questions ☐

continued ...

2. (iii) d) Some patients prefer not to be asked about their teeth ☐

e) Some patients talk more than necessary when questioned about their dental problems ☐

f) The NHS does not pay for non-operative time. ☐

g) Other reasons (please specify):

3. (i) How much should patients talk to their dentists?

a) A lot ☐

b) Quite a lot ☐

c) A little, but no more than is necessary ☐

d) Not at all ☐

(ii) How much do your patients talk to you?

a) A lot ☐

b) Quite a lot ☐

c) A little, but no more than necessary ☐

d) Not at all ☐

(iii) If how much your patients talk to you varies from patient to patient, which of the following is the most probable explanation?

a) Some patients are naturally more talkative than others ☐

b) Some patients are more concerned about their teeth than others ☐

c) Some patients think they are expected to talk ☐

d) Other reasons (please specify):

3. (iv) Which kind of patient do you prefer?

a) A very talkative patient ☐

b) A talkative patient ☐

c) A patient who only talks a little ☐

d) A silent patient ☐

(v) Do you enjoy talking to some patients more than others?

a) Yes ☐

b) No ☐

If you chose a), was your choice due to any of the following reasons?

a) Some patients are more interesting to talk to than others ☐

b) Some patients are more interested in taking care of their teeth than others ☐

c) Some patients have similar interests to my own ☐

d) Other reasons (please specify):

4. (i) How much time should dentists allow themselves for talking to their patients?

a) plenty of time ☐

b) quite a lot ☐

c) a little ☐

d) none at all ☐

(ii) How much opportunity should dentists allow their patients for talking to them?

a) plenty of opportunity ☐

continued

4. (ii) b) quite a lot ☐

c) a little ☐

d) none at all ☐

(iii) If the amount of time you and your patients spend on talking varies from patient to patient to which of the following reasons is this due?

a) Some patients are more interested in their dental condition than others ☐

b) Some patients are more anxious about their dental condition than others ☐

c) Some patients are more talkative generally than others ☐

d) Some patients expect their dentist to talk to them about their teeth, whereas others do not expect this ☐

e) Other reasons (please specify):

5. (i) How detailed should the dentist's description of the patient's symptoms be?

a) very detailed ☐

b) as much as each patient can understand ☐

c) just a brief outline ☐

d) no description is necessary ☐

(ii) How detailed is the description of the symptoms which you usually give to your patients?

a) very detailed ☐

b) as much as each patient can understand ☐

c) just a brief outline ☐

d) no description ☐

5. (iii) If you think some patients are able to understand more about their dental conditions than others, to which of the following reasons is this due?

a) Some patients are more interested in dental care than others ☐

b) Some patients listen more attentively to what the dentist tells them than others ☐

c) Some patients are more educated than others ☐

d) Some patients' understanding is more affected by stress than others' ☐

e) Other reasons (please specify):

6. (i) Should patients feel free to discuss with their dentists what treatment they would like?

a) yes, always ☐

b) yes, sometimes ☐

c) yes, but only in exceptional circumstances ☐

d) no, never ☐

(ii) Do your patients ever discuss with you what treatment they would like?

a) yes, always ☐

b) yes, sometimes ☐

c) yes, but only in exceptional circumstances ☐

d) no, never ☐

(iii) If some of your patients discuss with you what treatment they would like, to which of the following reasons is this due?

a) Some patients find it calming to be involved in the decision-making ☐

continued ...

6. (iii) b) Some patients are more interested than others in what can be done for their teeth ☐

c) Some patients expect to be involved in discussing treatments ☐

d) Other reasons (please specify):

7. (i) During treatment, how detailed should the dentist's commentary on that treatment be?

a) very detailed ☐

b) as much as each patient can understand ☐

c) it depends on the kind of treatment being administered ☐

d) just a brief outline ☐

e) no commentary is necessary ☐

(ii) How detailed is the commentary which you usually give patients during treatment?

a) very detailed ☐

b) as much as each patient can understand ☐

c) it depends on the kind of treatment being administered ☐

d) just a brief outline ☐

e) no commentary is necessary ☐

(iii) If you vary the amount of detail of your commentary from patient to patient, to which of the following reasons is this due?

a) Some patients are more interested in what is happening to them than others ☐

b) Some patients are more likely to understand my commentary than others ☐

c) Educated patients expect a detailed commentary ☐

continued ...

7. (iii) d) Some patients are too nervous to listen ☐

e) Some patients find a commentary calming ☐

f) Other reasons (please specify):

8. (i) How often should a dentist advise patients on how to look after their teeth?

a) very often ☐

b) sometimes ☐

c) as often as the patient needs ☐

d) never ☐

(ii) How often do you advise your patients on how to look after their teeth?

a) very often ☐

b) sometimes ☐

c) as often as the patient needs ☐

d) never ☐

(iii) If how often you advise patients on how to look after their teeth varies from patient to patient, why do you think this is so?

9. (i) When is the best time for patients to receive advice on how to look after their teeth?

a) as soon as the patient arrives ☐

continued ...

9. (i) continued ...

b) while the patient is being examined ☐
c) while the patient is being treated ☐
d) just before the patient leaves ☐
e) in a separate appointment ☐
f) there isn't a "best time" ☐
g) it varies from patient to patient ☐
h) other (please specify):

(ii) When do your patients receive advice on how to look after their teeth?

a) as soon as the patient arrives ☐
b) while the patient is being examined ☐
c) while the patient is being treated ☐
d) just before the patient leaves ☐
e) in a separate appointment ☐
f) there isn't a "best time" ☐
g) it varies from patient to patient ☐
h) other (please specify):

(iii) If the time you choose to give patients advice on how to look after their teeth varies from patient to patient, why do you think this is so?

10. (i) Patients sometimes fail to do what their dentists advise them to do. Some possible reasons for their failure are given below. Put 1 by the most likely reason, 2 by the next most likely reason and so on. Ignore any reasons that you think do not apply.

a) Patients forget what their dentists tell them ☐

b) Patients remember what their dentists tell them, but forget to do it. ☐

c) Patients are lazy ☐

d) Patients do not have time ☐

e) Patients do not understand what their dentists tell them ☐

f) It would be too troublesome to do what dentists advise. ☐

g) Patients do not listen to what their dentists tell them. ☐

h) Patients are not always appropriately advised ☐

i) Other (please specify):

(ii) How often do your patients follow the advice you give them on how to look after their teeth?

a) always ☐

b) quite often ☐

c) it varies from patient to patient ☐

d) never ☐

(iii) If some patients are better than others at following the adivce you give them on how to look after their teeth, why do you think this is so? Some possible reasons are given on the next page. Put 1 by the most likely reason 2 by the next most likely reason, and so on. Ignore any reasons you think do not apply.

10. (iii) continued ...

a) Some patients are more interested in dental care than others ☐

b) Some patients listen more attentively to what I tell them than others ☐

c) Some patients are more intelligent than others and understand what I tell them ☐

d) Some patients are more relaxed than others and can more easily understand what I tell them ☐

e) Some patients are more obedient than others ☐

f) Some patients are more forgetful then others ☐

g) Other reasons (please specify):

11. (i) Dentists talk about general matters of interest not concerned with treatment with some of their patients. Here are some reasons why they may do this. Which do you think is the most important?

a) it helps to fill silence ☐

b) it helps to make patients more relaxed ☐

c) it helps dentists and their patients to get to know each other ☐

d) other reasons (please specify):

(ii) Here are some reasons why dentists may NOT talk about general matters of interest with their patients. Which do you think is the most important?

a) It is a waste of time ☐

b) Patients go to the dentist for treatment, not to pay social visits ☐

continued ...

11. (ii) continued ...

c) talking prevents dentists from concentrating on their work ☐

d) dentists don't get paid for talking to their patients ☐

e) other reasons (please specify):

12. (i) Should dentists talk to their assistants while patients are being treated?

a) yes, because it helps to distract the patient's attention ☐

b) it makes no difference to the patient whether dentists talk to their assistants or not ☐

c) yes, so long as what they are talking about is relevant to the treatment ☐

d) only if it is absolutely necessary ☐

e) other opinions (please specify):

(ii) Do you and your assistant ever talk to each other when you are treating a patient?

a) yes, often ☐

b) yes, sometimes ☐

c) yes, but only occasionally ☐

d) no, never ☐

13. (i) What should be the relationship between a dentist and his patient?

a) impersonal and business-like ☐
b) personal and friendly ☐
c) business-like, but friendly ☐

(ii) Generally speaking, what is the relationship between you and your patients?

a) impersonal and business-like ☐
b) personal and friendly ☐
c) business-like, but friendly ☐

(iii) If your relationship with your patients varies from patient to patient, why do you think this is so?

14. (i) Generally speaking, how well do you think you know your patients?

a) very well ☐
b) quite well ☐
c) not very well ☐
d) not at all ☐

(ii) If how well you know your patients varies from patient to patient, is this only a factor of the frequency of their visits?

14. (iii) How easy do you think your patients find you to get on with?

a) always easy ☐
b) more easy than difficult ☐
c) more often difficult than easy ☐
d) always difficult ☐

15. Here is a list of reasons that patients sometimes give for feeling nervous when they visit the dentist. Put 1 by the reason which you think is most common, then 2 by the second most common reason, and so on. Ignore any reasons which you think are unlikely.

a) fear of having an injection ☐
b) feeling of helplessness ☐
c) fear of being hurt by the dentist ☐
d) not understanding what is happening ☐
e) the feeling that they can't express themselves adequately ☐
f) having to sit in the waiting room ☐
g) the feeling that they are not treated as individuals ☐
h) other reasons (please specify):

(ii) In your opinion, what can a dentist do to stop his patients feeling nervous?

15. (iii) Do your patients appear nervous when they come to see you?

a) yes, always ☐
b) yes, sometimes ☐
c) yes, but only occasionally ☐
d) no, never ☐

(iv) How can you tell that a patient is nervous? (please specify):

16. (i) Here is a list of methods that patients sometimes use to show a dentist that they are being hurt. Put 1 in the box by the method used most frequently by your patients, then 2 by the second most frequently used method, and so on. Ignore any methods not used by your patients.

a) the patient grunts or groans ☐
b) the patient grimaces ☐
c) the patient tries to speak ☐
d) the patient uses a signal pre-arranged with me ☐
e) the patient tries to move his head away ☐
f) the patient kicks his legs ☐
g) the patient grips the arms of the chair ☐
h) the patient arches his back ☐
i) other methods (please specify):

16. (ii) When do your patients let you know if you are hurting them? Put 1 in the box by the most commonly-chosen time, 2 by the next most commonly-chosen time, and so on. Ignore any answers which you think are not applicable.

a) as soon as I begin to hurt them ☐

b) after some time ☐

c) only when the pain is unbearable ☐

d) they never do ☐

e) at some other times (please specify):

17. (i) In your opinion what is the ideal workload for a dentist in terms of the numbers of patients to be treated per day?

(ii) On average, how many patients do you treat per day?

(iii) What factors condition the length of time you spend with each patient?

a)

b)

c)

d)

etc ...

18. (i) Which of the following words do you think will be understandable to the majority of your patients?

gingivitis ☐
pyorrhoea ☐
cavity ☐
denture ☐
dressing ☐
scaling ☐
amalgam ☐
tartar ☐
impression ☐

plaque ☐
anaesthetic ☐
molar ☐
crown ☐
extraction ☐
root filling ☐
salivejector ☐
plate ☐
socket ☐

(ii) If you think you use more technical words with some patients than others, why do you think this is so?

19. (Continued on next page).

19. How would you evaluate the patient you find easiest to deal with?
Ring the patient's position on each scale below:

e.g. ②

(i)	optimistic				pessimistic
	1	2	3	4	5
(ii)	friendly				unfriendly
	1	2	3	4	5
(iii)	dominant				submissive
	1	2	3	4	5
(iv)	tense				relaxed
	1	2	3	4	5
(v)	flexible				inflexible
	1	2	3	4	5
(vi)	communicative				uncommunicative
	1	2	3	4	5
(vii)	extrovert				introvert
	1	2	3	4	5
(viii)	fussy				not fussy
	1	2	3	4	5
(ix)	casual				formal
	1	2	3	4	5
(x)	knowledgeable				unknowledgeable
	1	2	3	4	5
(xi)	professional background				working class background
	1	2	3	4	5
(xii)	old				young
	1	2	3	4	5
(xiii)	male				female
	1	2	3	4	5

20. Here is a list of some types of dental treatment. Put 1 in the box by the type of treatment you have given most frequently in the past 12 months, then 2 in the box by the type of treatment you have given the next most frequently, and so on. Ignore any types of treatment which you have not done in the past 12 months.

a) fillings ☐
b) extractions ☐
c) prosthetic work ☐
d) crowns ☐
e) cleaning and polishing ☐
f) inspections ☐
g) orthodontic treatment ☐
h) preventive advice ☐
i) periodontic treatment ☐
j) any other treatment that you do regularly (please specify):

21. What percentage of your patients receive treatment:

a) on the National Health Service? ☐ %
or
b) privately? ☐ %

22. (i) On average, how many patients do you see each day?

(ii) Do you work:

a) with associates? ☐
b) in a dental hospital? ☐

continued ...

22. (ii) continued.

c) on your own? ☐

d) a combination of the above (please specify:

23. Please fill in the following information about yourself:

(i) Age ☐

(ii) Sex ☐

(iii) Place of work (ie. town) ☐

24. If you have any other comments about how and when you and your patients talk to each other, or about what you and your patients discuss, we would be glad if you would write them here:

If you would like to make any further comments, please write them on the back of this page.

Thank you for completing the questionnaire.

Please could you return it in the envelope provided.

University of Lancaster

Department of Linguistics and Modern English Language
School of English
Lancaster LA1 4YT

Telephone Lancaster 65201 (STD 0524)

September 1980

Dear Sir or Madam,

Dentist-Patient Communication

We have been asked by the General Dental Council to find out about the kind of communication used between dentists and their patients.

You can help us very much in our work simply by completing this questionnaire and sending it back to us in the reply-paid envelope.

Although the questionnaire looks long, the questions are easy to answer. We have found that people usually need only about half an hour to finish the questionnaire.

You are not asked to put your name on the questionnaire, and of course your dentist will not know what answers you give to the questions. You can be sure that all answers will be treated as confidential.

The success of our study will depend very much on the information which you provide. We should like to thank you in advance for your help.

Yours faithfully

C. N. Candlin
Project Director

NOTE: The questionnaire which follows has developed from a number of pilot drafts and we are grateful to professional dentist colleagues for their advice and criticism. The questionnaire will be distributed and the results will form the content of a subsequent Annex to this report.

UNIVERSITY OF LANCASTER

GENERAL DENTAL COUNCIL PROJECT

DENTIST-PATIENT COMMUNICATION

PATIENTS' QUESTIONNAIRE

7:3

A. HOW TO FILL IN THE QUESTIONNAIRE:

There are 22 questions in the questionnaire. Please answer each one.

Most of the questions have two parts. Please answer both parts, unless there are special instructions.

For most of the questions you should just put a tick (✓) next to the answer which you think is most suitable.

Sometimes you are asked to write your own answers, or to put a list of answers in the best order. In these cases there will be special instructions with the question.

B. FURTHER COMMENTS:

If you want to explain your answers, or if you have any extra comments which you want to make, we will be very interested to read what you have to say.

You can put your comments on the back of the last page of the questionnaire or, if you wish, on a separate sheet of paper.

UNIVERSITY OF LANCASTER

GENERAL DENTAL COUNCIL PROJECT

DENTIST-PATIENT COMMUNICATION

PATIENTS' QUESTIONNAIRE

CONFIDENTIAL

1. (i) What is a dentist's most important job?

a) to stop pain ☐

b) to prevent pain before it starts by treating dental disease at an early stage ☐

c) to calm and soothe nervous patients ☐

d) to give advice to patients so that disease can be prevented ☐

e) to give the correct treatment when patients need it ☐

f) to make the patient feel that he is a person not just a 'case'. ☐

g) don't know ☐

h) other (please say what):

(ii) Which of the following does your dentist pay most attention to?

a) stopping pain ☐

b) preventing pain before it starts by treating dental disease at an early stage ☐

c) calming and soothing nervous patients ☐

d) giving advice so that disease can be prevented ☐

continued ...

1. (ii) continued

e) giving the correct treatment when his patients need it ☐

f) making his patients feel that they are people, not just 'cases' ☐

g) don't know ☐

h) other (please say what):

2. (i) Should a dentist ask patients about the problems which they are having with their teeth?

a) yes, at every visit ☐

b) yes, sometimes ☐

c) yes, but only occasionally ☐

d) no, never ☐

e) don't know ☐

(ii) Does your own dentist ever ask you about problems which you are having with your teeth?

a) yes, at every visit ☐

b) yes, sometimes ☐

c) yes, but only occasionally ☐

d) no, never ☐

e) don't know ☐

3. (i) In your opinion, how much should a dentist talk to patients?

a) a lot ☐
b) quite a lot ☐
c) a little but no more than is necessary ☐
d) not at all ☐
e) don't know ☐

(ii) Does your dentist talk to you?

a) yes, a lot ☐
b) yes, quite a lot ☐
c) yes, a little but no more than is necessary ☐
d) no, not at all ☐
e) don't know ☐

4. (i) In your opinion, how much opportunity should a patient have to talk to the dentist?

a) plenty of opportunity ☐
b) quite a lot ☐
c) a little ☐
d) none at all ☐
e) don't know ☐

(ii) How much opportunity does your dentist give you to talk?

a) plenty ☐
b) quite a lot ☐
c) a little ☐

continued ...

4. (ii) continued

d) none at all ☐
e) don't know ☐

5. (i) In your opinion, should a dentist give patients any explanation about what is wrong with their teeth?

a) yes ☐
b) no ☐
c) don't know ☐

(ii) If you think that a dentist should give patients an explanation of what is wrong with their teeth, how detailed should this explanation be?

a) very detailed ☐
b) as much as the patient can underatand ☐
c) just a brief outline ☐
d) don't know ☐

(iii) Does your own dentist usually give you an explanation of what is wrong with your teeth?

a) yes ☐
b) no ☐
c) don't know ☐

(iv) If your dentist usually gives you an explanation of what is wrong with your teeth, how detailed is this explanation?

a) very detailed ☐
b) as much as I can understand ☐

continued ...

5. (iv) continued

c) just a brief outline ☐
d) don't know ☐

6. (i) In your opinion, should patients feel free to discuss with their dentist what treatment they would like?

a) yes, always ☐
b) yes, sometimes ☐
c) yes, but only in exceptional cases ☐
d) no, never ☐
e) don't know ☐

(ii) Do you ever discuss with your own dentist what treatment you would like?

a) yes, always ☐
b) yes, sometimes ☐
c) yes, but only in exceptional cases ☐
d) no, never ☐
e) don't know ☐

7. (i) In your opinion, should a dentist give patients a commentary on what treatment he is giving them during the treatment?

a) yes ☐
b) no ☐
c) don't know ☐

7. (ii) If you think that a dentist should give patients a commentary on what treatment he is giving them, how detailed should that commentary be?

a) very detailed ☐

b) as much as the patient can understand ☐

c) just a brief outline ☐

d) don't know ☐

(iii) Does your own dentist usually give you a commentary on what treatment he is giving you?

a) yes ☐

b) no ☐

c) don't know ☐

(iv) If your dentist usually gives you a commentary on the treatment he is giving you, how detailed is that commentary?

a) very detailed ☐

b) as much as I can understand ☐

c) just a brief outline ☐

d) don't know ☐

8. (i) In your opinion, how often should a dentist advise patients about how to look after their teeth?

a) very often ☐

b) sometimes ☐

c) as often as the patient needs ☐

d) never ☐

e) don't know ☐

8. (ii) How often do you put into practice the advice which your own dentist gives you about how to look after your teeth?

a) always ☐
b) quite often ☐
c) occasionally ☐
d) never ☐
e) don't know ☐

(iii) In your opinion, when is the best time for patients to receive advice about how to look after their teeth?

a) as soon as the patient arrives ☐
b) while the patient is being examined ☐
c) while the patient is being treated ☐
d) just before the patient goes home ☐
e) in a separate appointment ☐
f) at any time/it doesn't make any difference ☐
g) don't know ☐
h) other time (please say when):

(iv) If your dentist gives you advice about how to look after your teeth, when does this happen?

a) as soon as I arrive ☐
b) while I am being examined ☐
c) while I am being treated ☐
d) just before I go home ☐
e) in a separate appointment ☐
f) at any time ☐

continued ...

8. (vi) continued

g) don't know ☐

h) other time (please say when):

9. (i) Here is a list of some of the reasons why patients fail to do what their dentists advise them to do. Put 1 by the reason which you think is the most important, 2 by the next most important reason, and so on. If there are any reasons which you do not think are important, do not write anything by them.

a) patients forget what their dentists tell them ☐

b) patients remember what their dentists tell them but forget to do it ☐

c) patients are lazy ☐

d) patients do not have time ☐

e) patients do not understand what their dentists tell them ☐

f) it would be too troublesome to do what dentists advise ☐

g) patients do not listen to what their dentists tell them. ☐

h) patients are not always given suitable advice ☐

i) don't know ☐

j) other reasons (please say what):

9. (ii) How often do you put into practice the advice which your own dentist gives you about how to look after your teeth?

a) always ☐

b) quite often ☐

c) occasionally ☐

d) never ☐

e) don't know ☐

10. (i) Dentists sometimes talk about general matters of interest which are not connected with their patients' treatment. Here are some reasons which they give for doing this. In your opinion, which is the most important?

a) it helps to fill silence ☐

b) it helps to make patients more relaxed ☐

c) it helps dentists and their patients to get to know each other ☐

d) any other reason (please say what):

(ii) Here are some reasons why some dentists do not talk about general matters of interest with their patients. In your opinion, which is the most important?

a) it is a waste of time ☐

b) patients go to dentists for treatment, not to pay social calls ☐

c) talking prevents dentists from concentrating on their work ☐

d) dentists do not get paid for talking to their patients ☐

e) any other reasons (please say what): ☐

11. (i) In your opinion, should dentists talk to their assistants while patients are being treated?

a) yes, because it helps to distract the patient's attention ☐

b) it makes no difference to the patient whether dentists talk to their assistants or not ☐

c) yes, so long as what they are talking about is relevant to the treatment ☐

d) only if it is absolutely necessary ☐

e) don't know ☐

f) any other opinions (please say what): ☐

(ii) Does your own dentist ever talk to his assistant when he is treating you?

a) yes, often ☐

b) yes, sometimes ☐

c) yes, but only occasionally ☐

d) no, never ☐

e) don't know ☐

12. (i) In your opinion, what should the relationship between a dentist and his patient be like?

a) impersonal and business-like ☐

b) personal and friendly ☐

c) business-like but friendly ☐

d) don't know ☐

(ii) What is the relationship between you and your own dentist like?

a) impersonal and business-like ☐
b) personal and friendly ☐
c) business-like but friendly ☐
d) don't know ☐

13. (i) How well does your dentist know you?

a) very well ☐
b) quite well ☐
c) not very well ☐
d) not at all ☐
e) don't know ☐

(ii) Do you think that it is easy or difficult to get on with your dentist?

a) always easy ☐
b) more often easy than difficult ☐
c) more often difficult than easy ☐
d) always difficult ☐
e) don't know ☐

14. (i) Here is a list of the reasons that patients sometimes give for feeling nervous when they go to the dentist. Put 1 by the reason which you think is the most important, then 2 by the second most important reason, and so on. If there are any reasons which you do not think are important, do not write anything by them.

a) fear of having an injection ☐
b) feeling of helplessness ☐

continued...

14. (i) continued

- c) fear of being hurt by the dentist ☐
- d) not understanding what is happening ☐
- e) the feeling that the patient cannot express himself ☐
- f) having to sit in the waiting-room ☐
- g) the feeling that the patient is not treated as an individual ☐
- h) don't know ☐
- i) other reasons (please say what):

(ii) In your opinion, what could dentists do to stop patients feeling nervous?

(iii) Do you feel nervous when you go to see your own dentist?

- a) yes, always ☐
- b) yes, sometimes ☐
- c) yes, but only occasionally ☐
- d) no, never ☐
- e) don't know ☐

15. (i) Here is a list of the ways that patients sometimes use to show dentists that they are feeling pain. Which of these methods do you think is the most important?

a) the patient grunts or groans ☐

b) the patient shows pain by the expression on his/her face. ☐

c) the patient tries to speak ☐

d) the patient gives a signal which the dentist has suggested beforehand ☐

e) the patient tries to move his/her head away ☐

f) the patient kicks his/her legs ☐

g) the patient takes a deep breath or gasps ☐

h) the patient grips the arm of the chair ☐

i) don't know ☐

k) other ways (please say what):

(ii) Do you let your dentist know if you are feeling pain?

a) yes, as soon as the pain begins ☐

b) yes, if the pain has continued for some time ☐

c) yes, but only if the pain is unbearable ☐

d) no, never ☐

e) don't know ☐

f) at other time (please say when):

16. (i) In your opinion, how long should a dentist spend, on average, with each patient?

- a) 5 minutes or less ☐
- b) between 6 and 10 minutes ☐
- c) between 11 and 15 minutes ☐
- d) between 16 minutes and half an hour ☐
- e) between 31 minutes and an hour ☐
- f) more than 1 hour ☐
- g) don't know ☐

17. (i) Here is a list of some of the special words which dentists use. Put a tick by each word which you are already familiar with (without having to look for it in a dictionary).

- a) gingivitis ☐
- b) scaling ☐
- c) plaque ☐
- d) denture ☐
- e) pyorrhoea ☐
- f) anaesthetic ☐
- g) salivejector ☐
- h) molar ☐
- i) cavity ☐
- j) crown ☐
- k) dressing ☐
- l) extraction ☐
- m) root filling ☐
- n) amalgam ☐
- o) tartar ☐
- p) plate ☐
- q) socket ☐
- r) impression ☐

(ii) How do you feel when the dentist uses words which you don't understand?

18. Have you had any of the following types of dental treatment during the last twelve months?
(If you have had more than one type of treatment, please put a tick for each type which you have had.)

a) filling ☐

b) extraction (tooth taken out) ☐

c) new false teeth or alterations to existing false teeth ☐

d) crown (cap on a tooth) ☐

e) cleaning and polishing ☐

f) examination (inspection) ☐

g) straightening teeth ☐

h) don't know ☐

i) any other treatment (please say what):

19. (i) Do you normally have your dental treatment, with your present dentist, on the National Health Service (N.H.S.) or privately?

a) N.H.S. ☐

b) privately ☐

c) don't know ☐

(ii) How long have you been a patient of your present dentist?

(iii) How many times have you been to see your present dentist during the last twelve months?

20. (i) What is your date of birth?

(ii) What is your sex?

a) male ☐

b) female ☐

(iii) What work do you do?

iv) If you are married, what work does your wife/husband do?

21. Do you have any other comments about the way that you and your dentist talk to each other, or about the things that you and your dentist discuss?

If you would like to make any more comments, please write them on the back of this page.

Thank you for your co-operation. Please return the questionnaire in the envelope provided.

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